

DEADEND LIFE,
AN ANTHROPOLOGICAL VIEW OF AN
AMERICAN WASTED HOME

BY

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This dissertation is dedicated to the patients and
staff of Penn State Harrisburg — past, present and future

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CHANGING LIFE:
AN ANTHROPOLOGICAL VIEW OF AN
AMERICAN NURSING HOME

by

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This research project examines the experiences of chronically ill geriatric patients and the care-giving response patterns of unlicensed nursing personnel in a ninety-bed proprietary nursing home in southeast Oklahoma.

The study of the residents and staff of Swan Grove Home (pseudonym) is based on an anthropological community study approach, with theoretical orientations derived from Symbolic Interaction and social systems models. It consisted over a period of thirteen months of participant-observation. Patient data were also collected by personal interviews, scheduled interviews, patient diaries, still photography and cinematography.

Overall, Swan Grove Home is revealed as a standard American example of a specialized age-segregated community

which has become a commonplace institutional and health-care worker invention in response to immediately induced longevity, prolonged debilitating disease, and the ethical prescription against suicide. The nursing home, therefore, is the setting for observing the uniquely debilitating phenomenon of leading a "half-life of disease" within a "half-existence of social functioning."

The research also documents salient features of a resident population with a significant capacity to exhibit adaptive behavioral responses to physical limitations and the formal institutional environment. A further important finding about witnessed nursing personnel serving as "both teachers" and surrogate mothers to the patients and non-nursing personnel (i.e., housekeepers) is to be the key staff group whose normal or "proper" task performance provides transmission rather than vicarious contact with patients. In spite of patients' adaptive resistance, the nursing staff perceives patients as child children whose physical and intellectual resources are exhausted. This belief, generally coupled with medical-model-informed nursing neglect of psychosocial aspects of well-being, contributes to a web of fabricated life rituals that veil the underlying efforts at palliation care.

A concurrent integrative study of a special sub-group or cohort of twenty-three socially-isolated residents provides evidence that, in the end, they experience nursing home life not as ideal, but "the next best thing to home."

given their situation of unemployment and illness. This perception is partly based on fact, and is just a derivative of a need to counterbalance the insupportable stress of life under lockdown, compounded health threats and the related institutional confinement.

The significance of the role of the housekeeper as agents of psycho-social support is not formally recognized by either the nursing or administrative staffs. Unlike nurses' visits, proper job performance for housekeepers involves lengthy in-room tasks during which meaningful interaction can and does occur with individual residents. Housekeeper serves now as brokers between groups of residents and the nursing staff.

These findings as a whole suggest that institutionally-dwelling elderly are severely adaptively compromised for an extended period in personal body care, and do respond positively to informal or unplanned psycho-social care. It is argued that psycho-social care can be provided within an existing standard program by actively reworking the spontaneous social-support role of non-nursing staff members, like the housekeepers. The anti-beneficial nature of such a strategy is seen as potentially disastrous to geriatric nursing home owners for the degradation of the quality of institutional life.

CHAPTER ONE BACKGROUND

The representation of time, according to Mircea Eliade (1981), is a driving concern of all people throughout the world. Concepts of heterophanic experiences may represent the products of attempts to phenomenologically deconstruct represented time. In any case, the occupants of some worlds have in common the passage from mundane existence to supernatural existence, for example, from younger old age to unanchored old age.

Also observed worldwide is some form of practical segregation of the aged. Age-grading may be explicit as with the Senjōryō of Uganda (Nyam-Nyabun 1988) or implicit as with the Amerindians of North America. The segregation of aged people may be physical, as among the Ainu of Hokkaido, Japan, who isolate the very old in small huts (Kinsman 1948-50) or ceremonial, thus allowing for physical proximity of young and old but retaining distance mentally and ceremonially as found among the Christianized people of the northwestern United States (Baskin and Neijer 1975, 1981). Perhaps mental perspectives regarding the aged are ultimately functions of an awareness of the elderly approaching the mysterious phenomenon of death. Thus, people who have lived many years are viewed positively or negatively, as functional or non-functional, but always distinguished and distinctively engaged by others as aged.

Throughout time, the concept or label of "aged" has been assigned to people in accordance with prevailing beliefs regarding the chronological age at which someone "becomes" old. Assignment to the category of aged, then, is a construction of belief and time. In extremes, the six year old prodigious pianist is considered old while the Russian revolution or foundation hero are considered old only after reaching a purported (cf. Butler 1879b and Maistre and Thomas, 1977) 100 years of age.

During the middle Pleistocene, Neanderthal burials at Nevala Cave indicate that of a male about 30 years of age (Clark 1947 48) although most Neanderthal burials are of individuals less than 30 years of age (Binns 1967/68). McIlhenny's (1947-1951) excavations in Turkey show that very few of the Neolithic inhabitants of Catal Hüyük lived over 40 years of age. During the Iron Age (c. 1000 B.C.), the average life span was 16 years although some very individuals survived as septogenarians (Gibson and Clayton 1975 13). By 50 B.C., the life span had increased to 18 years until the 1000s A.D. when the life span edged closer to 20 years of age (Gibson and Clayton 1975 14).

During the year 1734 A.D. in America, only 20% of women lived to the age of 70 and only 4% of American families were comprised of three generations (Gutler 1978a: 11). By 1900, the human life span was 47 years and in 1970 it was 71 years of age (Butler and Harootyan 1973 33-34).

rather (1978-85) projects that the maximum limits of human longevity range between 120 and 125 years.

Given the rapid acceleration of human longevity and its tendency, "old" is not in America and the world. It is as if a new sub-species of *Homo sapiens* has evolved as a product of machine-age longevity and scientific medicine. While the anthropological designation is *hominids*, it can be surmised that elderly people are in some ways physically, mentally and intellectually diverging. These distinctions (e.g., change of bone density, change of arterial elasticity, digestive changes, cognitive and memory capacity changes) relate to special needs of the elderly and finally to demands placed on society pursuant to meeting these needs.

The importance of addressing the needs of the elderly in America becomes clear when demographic trends are examined. The total population aged 65 and over in 1900 was 3.1 million but in 1970 was 19.2 million. The proportion of people 65 and older has increased almost 2 1/2 times from 1900 to 1970; 4.1% to 9.8%. However, the percent of the total population 65 and older will be 11% in 1980, decline slightly until 2000 when it will rise to 10.4%. Projections for the next five decades show that the absolute number of people 65 and older will increase from about 19 to about 40 million (Gutler and Garofano 1973:25-30).

The rapid increase in the number of aged Americans has produced a series of attempted societal adjustments aimed at

adopting modern American life is a new element of the social and cultural system. In this sense, postcolonial evolution is proceeding under the guise of federal and local governmental programs providing services for needy elderly while also functioning to shift responsibility away from individual elderly persons and their families to the general public. Monetary assistance for the aged, treatment and nursing facilities for the aged, separate communities for the aged, and simple retirement appear to be the American ways of dealing with the growing aged population. Thus, the American aged population has been identified, categorized, and stigmatized as a "problem" with which the "world" must cope.

Throughout the United States, the vast majority of aged people (therefore excluding those persons 65 years of age and older) live in community settings with 72 % of aged males heading a household. Relatively few aged people live alone (14.7% male; 34 % female) and even fewer live in institutional settings (5 % male, 4.8% female) (Hether and Parsonson 1973:83). This minority of institutionalized aged, however, currently total 1.8 million people (Brody 1976:83) and projections indicate that by the year 1988, there may be 11 million aged people residing in institutional facilities (Brody 1976:100).

The institutional setting likely to be encountered is a privately-owned, profit-operated business utilizing various degrees and types of care to the elderly aged. According

in Butler (1979:107). 70% of all expenditures providing care for the aged sick are proprietary in nature. Nonprofit institutions for the aged provide care for 14% of the institutionalized aged and 21 of the institutionalized aged are in government-funded facilities.

Characteristics of institutionalized aged populations are varied, but even so, certain characteristics of trends are apparent. The median age of institutionalized people is 81 with 42% age 85 and older. There are three times as many women as men. Most institutionalized people are white and poor and are maintained by public funds. The institutionalized aged population is likely to have a variety of chronic physical ailments including circulatory disorders, arthritis, digestive disorders and mental impairment such as senility and depression (Brady 1979:15-19).

Additionally, many institutionalized aged people have no spouse, no close relatives and the majority have no visitors. They stay in the institution almost 1.5 years with only 50% returning home, the remainder dying in the institution or at a hospital. Few can walk, 50% are incontinent and there is an average of more than four drugs taken per person each day. Mass and Schneiderman (1979:40)

The above description projects a dismal existence for the inhabitants of geriatric institutions. If to be institutionalized is to be poor or sick or lonely, then the combination of these three elements can only constitute a compounded sense of demoralizing degradation. Yet, in this

Investigation is a proprietary working team, the harsh reality of the participants' situation is tempered by the human ability to adjust and adapt to prevailing circumstances. The circumstances to which these aged people must adjust and adapt center about the aging issue or the "working team."

Care for the sick elderly is known in all societies regardless of the level of technological proficiency or sociopolitical organization. The existence of sanatoria among both nomadic and tribal societies is not uncommon, but exists only when necessary. The usual nurturing functions are related to vital components of food and tribal subsistence, mobility and productivity. Those who interfere with these basic requirements are killed or allowed to die (Kimmer 1944 and 1945). Among some state level societies, such as the Aztecs of Peru and the Aztec of Mexico, tribute from the productive citizens was redistributed to the needy including the infirm elderly (Kimmer 1942:78).

Another aspect of aging recognized cross-culturally is a distinction between productive old age and nonfunctional old age. The nonfunctional and often sick elderly are referred to as "parasitic" "useless," in the "slumping period," in the "age-grade of dying," and "wretched and" (Kimmer 1945:87). Among the Hopi of Arizona, for example, when people are in the "helpless stage" their death is avoided by purposeful neglect (Kimmer 1945:88).

The concepts of an American nursing home are often very old and very rich. Their membership in a psychiatric institution is a symbol of their inability to cope with even the simplest aspects of life unassisted. In response, the psychiatric institution has evolved as a cultural product of technological society's ability to sedentize biological life for an extremely long duration but with unproven functional aspechtp. Thus, nursing home patients find themselves the victims of a peculiar American pathology...

chronic life

The nursing home in America has a lengthy evolutionary history. Cohen (1984) reviews the development of institutionalized care for the aged in six phases. The first is labeled the "colonial period" referring to the 17th and 18th centuries. There is ward (aged, orphan, sick, prisoners) all had measures to state valued programs. Overall, however, "insidious relief" (i.e., institutional care) was more common prior to the Revolution than after it when the almshouse became the popular mode of dealing with the needy.

Second, from 1840 to 1870, America was heavily influenced by England's Poor Law of 1834. The Poor Law clearly established the almshouse as the primary destination responsible for the care of all needy, including the aged. The enactment of life in the almshouse was a matter of policy so that it would not be attractive in the unfavouring. It was not until the 19th century that humanitarian reforms

facilitate the development of institutions specifically designed for long-term care of the aged.

During Cohen's third phase, 1909 marks the date by which nonprofit institutions were primarily responsible for care of the elderly. The program of the Social Security Act subsequently provided assistance for the aged. Privately-owned boarding houses began to house the elderly and when nurseries were added, the boarding house became a nursing home. By 1919, Cohen's fourth phase, there were 1269 long-term care institutions with a 25,000-bed capacity nationally.

By 1934, Cohen's fifth phase, there was a noticeable increase in the number of proprietary nursing homes. The number had risen to 25,000 institutions with a 400,000-bed capacity. Cohen suggests that this increase reflected a backlog of potential patients.

After 1945, Cohen's sixth phase, long-term care became institutionalized into the fabric of government policy, medicine and medicine. In 1965, legislation allowed funds to nursing home patients and passed the Older Americans Act. The number of facilities expanded and in 1971 there were 4.3 million nursing home beds.

It was during the phase of rapid expansion of nursing homes in the U.S. that Peace Green House (quadrupled) nursing home was built in southern Oklahoma. Peace Green House was built in 1963 as a 20-bed proprietary facility. Within two years, it was expanded to a 40-bed facility and within

another three pages. 50 more beds were added to the 500 present patient load at 80. Seldom does the patient load drop below the maximum capacity.

CHAPTER TWO NOMINOLOGY

Team Event Study was initially restricted to a preliminary research visit because the administrator is the author's mother's brother and thus, a close kinsman. The time-consuming negotiations and development of support that would accompany implementation of Fieldwork among strangers was consequently reduced. Advantage could be taken of the researcher's kin network only if such a relationship would not compromise objectivity and access to data. Finally, permission to engage in research was needed from the administrator as well as the cooperation of staff and patients. All of these activities were met, leading to field entry in June 1971.

A research effort affording complete access to all components of a proprietary nursing home is unusual. This project thus represents a departure from many studies regarding the phenomenon of aging. In fact, research among the institutionalized aged has been relatively neglected based on a review, for example, of the Journal of Gerontology from 1948-1979 (i.e., volume I through the present) and the Index Medicus from 1967-1979. This is particularly conspicuous when compared to the relatively voluminous literature on other gerontologic topics.

Anthropologists have virtually ignored the institutionalized aged from 1948-1979, before 1948 and only a few gerontologists have used anthropological methodologies

(Opler 1975). Some have used anthropological perspectives. Of the research activities reported by my social science discipline among the institutionalized aged, is in my distinct impression that the overwhelming majority are based on data gathered in nonprofit nursing homes affiliated with some organized religious group. This is particularly noteworthy in view of the fact that 70% of the institutionalized aged live in proprietary nursing homes (Opler 1975: 261). The few reports of research in proprietary nursing homes are generally not recent and are superficial treatments of a very complex social setting (e.g., Burt 1931, Bales 1937, Keweenaw and Keweenaw 1942).

Anthropological investigations in a proprietary nursing home is particularly appropriate. Not only does such an effort fill a gap in studies on aging, but the anthropological brings powerful perspectives and methodologies to empirical work that are seldom found in other human sciences. The concepts of holism coupled with participant-observation data collection provides comprehensive, in-depth verification of conceptual themes (Opler 1942) and uniqueness of cultural systems.

Furthermore, the methodology of participant-observation has proven useful in a variety of institutional health-care settings. Gerd Taylor (1976, 1977) provides insight into the experience of nurse/patient interactions by understanding the array of nonmedical manipulative behaviors exchanged among health care personnel and patients and their

atypical circumstances. Buckingham et al. (1970) employed the lives of dying patients as a palliative-care ward in an acute-care hospital. Rosenhan (1973) gained ethereal and valuable data on the effect of labeling and institutional treatment of not-so-mentally-ill volunteers. The closest precedent for this study is by Shanon (1972) who engaged in participant-observation studies in a nonprofit, residential nursing home.

Participant-observation is not new nor does it possess the infectious glamour of statistically-sanitized quantitative studies for key-punching and resulting in means of computer-filled data. Before computers (an anthropology) existed, Professor LeFlore studied French peasant families by living in their homes with them (Glennfield 1947). With the formalization of anthropology as a distinct field of inquiry, intensive coexistence with the subjects of study has been upheld after anthropologists such as Franz Boas and Bronislaw Malinowski of the early twentieth century. Thus, the "art and science" (Folke 1970) of participant-observation fieldwork has established a firm basis for its use (Datta 1975; Latané 1970; Glaz 1970).

Participant-observation was selected as the primary data collection technique at Fagan House since because of its personal, experiential nature. Suspicious naturally felt about the ulterior goals of proprietary nursing homes would assure data collected by government statistical compilations, questionnaires, mail surveys or other techniques

characterized by negligible encounter with the subject population to be questionable. Conversely, participant-observation allows for first-hand data collection, in-depth experience, and observation of formally-stated ideals of behavior compared to actual expressions of behavior.

My personal use of participant-observation at Tecon from 1969 was the entire genre of possibilities except being formally institutionalized. Although the fieldworker may be considered to totally immerse himself in the culture of the study population, there actually exists daily situational fluctuations of degree of participation and observation (Holt 1988). My involvement was allowed for the total system in all participants: administration, support staff, patients, and families. However, because proprietary nursing homes tend to expect negative assessments and in fact are continually under the scrutiny of government inspectors (not to mention families), observing and writing notes in public were perceived some difficulty. In anticipation, I had written nothing in public and carried no notebook for the first few weeks after my arrival. As the stress began to take more notice to me, the need to preserve my increasingly numerous meaningful observations required the immediate joining of notes to a field notebook.

In the day that I first began to write notebooks, minutes, I constructed a room which would allow patients and staff to see me taking notes and with the permission for them to actually read what I had written. I selected a table

in the corner of the lobby under a ceiling spotlight. Being a large notabson and wearing 11, I began to conspicuously look about and then turned up observations. I purposefully avoided any entry of a potentially sensitive nature, such as "waited" side Minister in passing off," etc.. As I responded, the "waiters" became increasingly restless. The waiters' activities were all perceptions of the nursing home who finally walked away, barely glancing at me and then later returned to loudly speak to an overly endearing time to some "assist" patients. After all, I was the home's nephew who had been sent to "help" me then.

Within fifteen minutes of my exit, the assistant administrator and the R.N. very quietly came from behind me and peered over my shoulder. When I noticed them, I moved my arms away from my notebook, leaving it totally exposed and unattended. They immediately asked me in a friendly, shy way what I was writing. I handed over the notebook explaining that the two pages of notes were just a beginning and that I would surely require their assistance in the future. The nursing settings were handed back to me and business went on as usual with several more months of a "simplified matter" (cf. Franklin 1975) exhibiting uncharacteristic "note taking behavior" (cf. Newman 1971).

My extent of participation included helping as a janitor, taking patients to the physician, going to the home of a prospective patient and experiencing the trip from their community home to the nursing home, being in a play as

celebrate the Fourth of July, and working as a paid employee (Gruen's aide). Thus, I was able to observe and experience much of nursing home life during my thirteen-month stay. Although it is obvious, I never personally experienced being an old, sick, nursing home patient.

Because I could not experience age beyond my years or experience the length of a hallway for an arthritic patient, other data collection techniques were used. Notable is a scheduled interview given to staff, families, and selected residents. The interview schedule contained questions specific to the respondent's role classification, but each also contained a common core of questions for intergroup comparison. Personal open-ended interviews were collected, patient diaries collected, with still-photography and sound cinematography completing the data-collection activities. The intent here was to maximize the quality of data collected by using a multi-instrument research design involving direct personal participation and observation.

In the larger view, the analytical framework used is based on the model for community study (Grossberg and Kossell 1981; Howard 1980). Conceptually, I approach Pease Green Manor as I would any other society regardless of geography. Pease Green Manor is thus viewed as a small community with its peculiar beliefs, behaviors, boundaries, rituals, the incorporation and expulsion, etc., existing not as a whole, understood in its totality, but as a part of a network of other social groups of variable influence.

While Rosenberg and Rothall (1974) emphasize that a community is a microcosm of the cultural system of which it is a part, Bernard (1970) states that a single community cannot be absolutely representative of its cultural system (Greene and Anderson 1974). Much the same consideration must be made here. Peace Grove Manor, as a community of institutionalized elderly, cannot be absolutely representative of all other nursing homes. However, those which control parameters that cause the methods used here and the subsequent findings to be useful in the investigation of other age-segregated, institutionalized settings. For example, Peace Grove Manor is included in the following attributes of contemporary American nursing homes: the typical nursing home is a privately-owned business, the physical plant is most often a spate of rail-lined corridors connecting large distances, the patients are generally very old (80s) and there is a three-to-one female-to-male ratio, most patients are widowed, most employees are untrained nurses' aides, patients have few visitors and seldom leave the nursing home grounds, and of those who are admitted to a nursing home and do not ultimately move to another long-term care facility, most die there or die shortly after transfer to a hospital. In these important factors, Peace Grove Manor is strikingly similar to the profile of other American nursing homes (Rosen and Selinger 1977).

CHAPTER THREE DEMOGRAPHICS AND EPIDEMIOLOGY

The patients of Faxon Grove Manor are institutionalized because of some physical or mental disability. The degree of disability among the patients is variable but must be serious enough to warrant full-time care as judged by physician assessment. As a nursing home, Faxon Grove Manor is essentially a living environment designed to support a population of aged, debilitated people suffering the extended effects and acute consequences of chronic diseases. The purpose of this chapter is to develop a demographic and epidemiologic profile of Faxon Grove Manor's health and disease environment. These data will be used to significantly influence the sociocultural environment of this geriatric community. Thus, chronic disease and sociocultural systems mutually influence each other.

Essentially all states in America must address the needs of the expanding aged population. Those states which currently have large aged populations may serve as prototypes while other states observe and analyze these circumstances for adaptation. Oklahoma is one such "pioneer state" with regard to aged populations. Demographically, Oklahoma ranks seventh nationally with 12.3% of the total population 65 years of age and older (See Figure 1).

In reflection of Oklahoma's sizeable aged population, 7% of the \$418 per capita health care expenditures in 1974 went to pay for nursing home services (Oklahoma Health

1	Florida	18.4%
2	Arkansas	13.3%
3	Iowa	12.4%
4	Wisconsin	12.3%
5	Michigan	12.2%
6	North Dakota	12.2%
7	Illinois	12.1%
8	Minnesota	12.1%
9	California	12.1%
10	Idaho	11.9%
11	Pennsylvania	11.4%
12	West Virginia	11.4%
13	Massachusetts	11.3%

Compiled from The Elderly Population: Estimates
by County, 1916. Data #00000
18-00048

TABLE IV. 1. OF TOTAL STATE POPULATION 634, 1916

Figure 3

Systems Agency 1978-84). Also, Oklahoma's availability of nursing home beds is high. In 1971, Oklahoma had 82 beds per 1,000 population 65 and over, compared to the national figure of 81 beds per 1,000 population 65 and over (See Appendix 1).

The geographic distribution of Oklahoma's aged population is associated with urban and rural areas (Oklahoma Health Systems Agency 1978-84a). The two large urban areas of Oklahoma are Oklahoma City (Oklahoma County) and Tulsa (Tulsa County). Other rural counties in the state have significantly higher populations of people aged 65 and over (See Figure 2). Of all the 77 counties in Oklahoma, Marshall County has one of the highest aged populations. It is in Marshall County that Ponca Grove Manor is situated (See Figure 2).

As a population ages, the prevalence of chronic non-infectious diseases increases. The epidemiologic profile of Ponca Grove Manor patients is characterized by a high prevalence of such diseases (See Appendix 3). Of all the disease entries in Appendix 3, arthritis has the highest prevalence rate (See Appendix 3). When the diseases at Ponca Grove Manor are collapsed into categories used by the Burgh Hays), cardiovascular, neurologic, psychiatric, and musculoskeletal/fracture chronic diseases are by far the most prevalent (See Appendix 4).

The patient population at Ponca Grove Manor is predominantly female (78% female, 22% male) and the average age is



PERCENT OF POPULATION 65+ IN SELECTED COUNTY

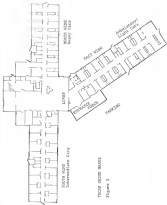
Figure 2

75 A population pyramid of the patients shows the greater percentage of female patients to male patients begins in the seventh decade and persists through the eighth decade (See Appendix 15). The predominance of women is still preserved when staff is included in a Penn State Manor patient/staff population pyramid. Thus, when considering the patient and staff populations, Penn State Manor nursing home is predominantly female and middle-aged (average age of patients and staff is 51.7 years).

The patient population is divided into three physically and conceptually distinct units based on degree of disability. Penn State Manor is essentially three nursing homes in one. The configuration of the physical plant is based on "wings" radiating from a core containing the lobby, dining room, nurses' station, and administrative offices (See Figure 11). Assignment to a wing is based on one's level of disability and thus the type of nursing care required.

General observations give the impression that each wing is characterized by distinctly different disease entities. The level of care required on each wing would appear to be a function of progressively more serious disease types. However, disease distribution throughout the nursing home is even. Wing assignment is not related to the source of disease found on the patients' charts.

Four factors are related to wing assignment and do not require physician assessment or orders in patient charts. In addition, the prospective patient is assessed by the



Floor plan of building

Figure 2

1.3. another significant achievement occurring is consciousness, stimulation, location of need-taking, and ability to feed one's self. These four patient-management features determine wing assignment.

The wings at Penn State Harrisburg are called by the cardinal direction with which they most closely align (See Figure 14). The North Wing is closest to the nurses' station, personnel, medications and medical equipment. These patients on the North Wing are most likely unconscious, semi-conscious, and unable to feed themselves and may be fed. The diseases found in this wing are the same found throughout the nursing home but the degree of disability is greatest here. The efficiency of care delivery is enhanced by the proximity of the nurses' station to the wing requiring the most patient care.

At the other extreme, the East Wing houses people who are most likely to be conscious, ambulatory, dining room users, and self-feeding. This wing is farthest from the main nurses' station. Bldgs are call lights used on this wing. In fact, patients desiring "paw" (i.e., as often as needed) medications typically walk from their rooms to the nurses' station to make such a request.

The South Wing represents an intermediate transition between the "heavy care" and "light care" wings. Here the ambulatory, dining room users who feed themselves are moderately represented relative to the other wings.

However, incontinence is highest on this wing. This is due to ambulatory patients with urinary incontinence and non-tubed-only urinary incontinence.

In summary, patient-management strategies are less related to specific disease categories and more related to level of debility as indicated by degree of continence, ambulation, ability to feed one's self and location of meal-taking (See Appendix E). In this way, Penn State Harrisburg knows where nursing homes lie now. The patients, staff, and visitors know and are affected by the design of patient-management and the physical environment.

CHAPTER FIVE ENVIRONMENTAL SETTING

The physical plans of human groups almost always comprise a setting in which persons and organizations engage in activities for significant parts of their lives. For persons particularly, the physical plans represent the environment which they must negotiate in order to interact with others, get satisfaction, and otherwise live their lives. The staff, too, must perform within the confines of the building. If all conditions often make about getting from one patient to another which actually means one location to another. Thus, the configuration of the physical plant has the potential to "smear" certain behaviors from the inhabitants (Homer 1981).

Consideration for the environment as an influential component of human societal existence has a lengthy tradition in anthropology. Perhaps the cataloging of "ecotic" food items, shelters, medicines, rituals, etc., required at least a superficial treatment of the environment as the source from which these "goods" were extracted. An environment became a mere context term in social sciences. Human ecology emerged as "the descriptive study of the adjustment of human populations to the conditions of their respective physical environments" (Kroeber 1945:404). Later, anthropology took account of environment from the cultural ecological perspective of the interactive physical and cultural environments (Ostrow 1980).

If specific experiences here in a special type of environment known as an institution. Goffman's (1960) analysis of "total institutions" underscores the oppressive nature of the "institutional" life in a heavily controlled habitat. While prisons or mental hospitals may be characteristic of total institutions, many nursing homes and particularly Paces Grove Manor, are not.

Reisner and Salzman (1965) have developed a system of ranking an institutional facility according to its degree of institutional totalizing. Their perspective maintains that a nursing home represents a significantly different living environment compared to independent community life and that while a nursing home may approach the total institution, it often falls short of this extreme.

To assess Paces Grove Manor along a continuum of institutional totality requires a review of the environmental setting encountered by patients and staff. The building is comprised of three corridors attached to an open nurses room (see Figure 1): Corridor architecture seems to characterize the physical plant of many institutional facilities (Hodgson 1961; Bennett and Binderfer 1973; Grier 1973; Rosenfeld 1976). Butler (1971) even refers to the "cave-like" appearance of many nursing homes.¹

The corridor design of Paces Grove Manor deviates from the usual image in that all corridors are lined with handrails. The rail-lined corridor is the distinguishing feature of many nursing home environments. Architecture amplifies my

have handrails, but usually only in physical therapy areas, and residential homes are devoid of such devices. While hospitals share with nursing homes items such as bedrails, hipsters, electrocardiogram, and white uniforms; and private residences share with nursing homes things such as personal furniture, pajamas, and hairbrushes, the continuous rail-lined corridor is to be found not in the hospital or private residence, but only in the nursing home.

The handrail is both a metaphor and artifact of periventricular institutional life. In the hallway of a staircase implies that use of the stairs is a risk, handrails in a nursing home are prominent visual symbols of people whose lives are at risk. Still, the handrail remains a needed prosthesis and is thus a cultural artifact supportive of those people with diminished strength or poor balance.

The rail-lined corridor is public space. Activity in the corridor is always single locomotion from point A to point B. Use of the corridor as a public pathway places one on display to all those within seeing distance. Thus, one's abilities or disabilities become commonly knowledge.

Each of Penn State Harrisburg's three corridors lead to the main lobby area. The lobby is intended to serve as a central location for patient information and activities. Here are found reading machines, a video television, magazines, a plant, and sponsored chairs, benches and railings. In spite of these various attractions the lobby at Penn State Harrisburg is an area of little patient-to-patient interaction.

Observations in other nursing homes disclose a similar lack of use.

In the current state of the art of building of nursing homes, lounges must be regarded as the single short-
 com failed as a concept. Typical
 lounges are the result of regulations
 which specify that so many square feet
 must be devoted to lounge space on the
 basis of number of beds. This device
 usually results in one or more very
 large areas devoted to socialization,
 relaxation, and contemplation, but not
 really accommodating any of these
 activities. (Dunsmuir, 1978)

In one corner of the main lobby is the color television
 set. The television area is marked by horizontal vinyl-
 covered benches facing the television and situated about
 4 to 14 feet from the screen. While it is common to see
 patients sitting on these benches, seldom is anyone actually
 engaged in watching some program. Often patients fall
 asleep sitting up or seem to witness any distraction
 (such as conversation with the researcher, an aide, a
 phone call, etc.). In one instance, the volume control on
 the color television broke, leaving video without audio.
 The office personnel placed a small black-and-white portable
 television next to the color set to use for the audio por-
 tion of program. After a few minutes a patient changed
 channels on the cordless color set. The picture on the
 color television never reached the sound on the black-and-
 white set for the remainder of the day. Still, patients
 came to the television area, sat or slept, and then left,
 never noticing the video/audio disconnect.

Several factors relate to the television area's inability to actually engage the potential viewer. Heavy deficiencies may make seeing the screen and hearing the sound difficult, particularly in a heavy-traffic area such as the lobby (cf. Gonzalez 1994:110). At times, when the television sound is loud, viewers' sides lower the volume or as soon as no one is in the television area, turn the set off.

Also, many patients have potential television in their rooms complete with cable service. The television area serves, too, as a brief rest-stop on the way to the dining room. When food trays are served, the television area is immediately vacated.

Television using patients in the lobby is further debilitated by the arrangement of chairs and couches. The chairs and couches represent long lines of seating which occasionally meet at right angles. For persons with decreased sensory perception and physical mobility, sitting in lines of seats facing directly ahead requires difficult bodily adjustments to enable each person to meet to see and hear the other. The degree of difficulty posed by these communication obstacles is such that little interaction takes place while seated in the lobby (cf. Gonzalez 1994:11, Rimmer 1990:24-29).

The vending machines (soft drinks, potato chips, nuts, candy, cigarettes) are located along a wall away from activity areas. In contemporary American culture, the

radio presents crash-type foods as vehicles which fuel social interaction and cannot resist this. Nonetheless, the meeting machines do not have chairs or tables clustered nearby to take advantage of the Madison Avenue promotion for food/drink-oriented interaction.

Thus, the main lobby feels as an arena of lively private interaction in daily use. The only times at which the main lobby becomes the location of significant interaction are those of scheduled ritual events staged by the working home staff major community. These events include weekly religious services, civil/religious ceremonies (Independence Day, Mother's Day, Memorial Day), and Jewish-Christian celebrations (Christmas, Easter).

The main lobby does, however, produce an impression of a spacious "homey" atmosphere. The institutional nature of Evans Grove House is masked by residential-type furniture, carpeted rooms, and soft pastel wall colors. There also are plants with green plants and decorative wooden support posts with wicker-stake stringers framing the nurses' station. Lighting is primarily by recessed moon bulbs, but even so, table lamps are present in the lobby. Overall, the lobby generates in the observer a positive feeling about the working home as a whole.

Certain areas of public open space do be conducive to interaction due to some accidental configuration of design elements. Adjacent to the main lobby is a zone which serves as the main entrance to the working home. The outdoor area is a natural unplanned conversation zone.

The main entrance area promotes patient interaction by its position as a vantage point for observing the daily events within the nursing home. Other observers likewise view entrance areas as natural vantage points (Gibelman 1933: 30, Gansslik 1974: 38, Jensen 1978: 34). Sitting in the chairs or area near the chairs facing the entrance doors, one can see through the glass doors and adjacent glass panels to the parking area and the nearby highway. This view allows for monitoring the travels of patients, visitors, and staff. Also visible right in the nursing home business office with its attendant activities. Looking to one side offers the view of the entire ambulatory corridor. Patients move within in the corridor frequently for visiting, medication, food, and exercise. Looking to the other side affords a comprehensive view of the main lobby, dining room and nurses' station. For those patients whose mental abilities permit, the entrance area provides a good all-around location for gathering information about the daily events of nursing home life.

The entrance area is also marked by its function as a communication center. Here is found a phone for patients to use, a large monthly announcement and event calendar, and a major-board bulletin board. This area also is marked by many wall-to-photographs of past parties. Live plants are also here along with craft displays.

The entrance also stimulates interaction due to its well-point location between the ambulatory corridor and the

lobby/waiting areas/nurses' station cluster. Traffic in either direction can, for surveillance or security, stop here to rest, observe and talk.

Social interaction is thus promoted in the entrance area by numerous prearranged features. Waiting in this area is limited, however, and most nurses are those who have reached higher levels of functioning. This part of the nursing home physical environment serves as a central location for patients to learn of various activities occurring in "their" building and to exchange information which is then diffused in the other corridors of the physical plant.

Floor space area, whether lobby, entrance, or patient room, is determined by formulas based on the number of patients housed. The main lobby fulfilled the space requirements for the first thirty-bed unit and the second addition of another thirty beds. When continued construction added an additional thirty beds, however, additional lobby space had to be built. This new lobby area is at the end of the subsidiary section. In this new lobby about one-third the size of the main lobby, more intrasectored activities occur.

Interinstitutional activities include weekly bridge games, activities such as singing and craft work, daily coffee games, and other patient/family activities such as private parties. The new lobby area also serves as a place for large groups of visitors to see their relatives.

The final area of public space to consider is the dining room. While most other biological needs can be met in the patient rooms, eating in the dining room is considered indicative of a relatively high level of functioning. The administration and nursing staffs encourage dining room use for the change of scenery and social interaction. Even so, seating placement is fixed so that forgetful patients will not be so easily confused.

The dining room, like the lobby, is a place of very little social interaction. Meals are brought to the tables by the kitchen staff on large disservice trays. In an effort to serve the food hot or cold, and to satisfy hungry patients, great haste is made in getting food trays to the tables. The result is that the kitchen staff has little time to exchange pleasantries with the patients at the tables.

Other obstacles to minimization of malnutrition are related to sensory deficiencies in the patients. The hearing-impaired patient has difficulty understanding another from across the table. Deaf-blind vision may further hamper communication by distorting lip-reading. Additionally, the kitchen is adjacent to the dining room where a very loud dishwasher operates during meals (cf. Somerville 1978 [9]). Thus, food service responsibilities, sensory deficiencies, and environmental noise function to inhibit nutrition interaction.

While the labiles and entrance area are zones of public space, there are zones of private space. The private space zones are those controlled by the nursing and administrative staffs. At the nurses' station can be found the L-R (L = , registered nurse), L-P R-n (L = , licensed practical nurse), patient charts, and medications. The area behind the nurses' station marks the private space for staff only. Here the nursing staff can work on charts or medications with minimal patient contact. The privacy of this zone enables the nursing staff to exchange medical information as well as gossip about patients, other staff members, or their community lives.

The nursing staff also converts part of the public dining area to private space for breaks and staff meetings. The "break table" functions as channel area throughout the corridor to the nurses' side. Thus, staff assigned elsewhere can listen important interventions to which they were not witness.

While all staff members spend many hours of each day within Room Drive Manor, only the patients live the entirety of their remaining time in the institutional environment. Most of their time is spent inside their rooms. An empty room would look much the same as any other throughout the nursing home. However, each wing has its own distinctive atmosphere when filled with patients and their belongings.

The three-winged configuration of Faxon Grove Manor has been used to assign patients to a particular wing not based on specific disease entities but rather on a subjective assessment of individual ability. Assignment provided has led to describing the wings by level of care needed and has resulted in clustering of physical capacities (See Appendix 4). Likewise, the artifacts in patient rooms reflect the level of ability of those living there.

The North Wing, or "heavy care" wing, houses those patients with the greatest physical and mental difficulty. An avowed inventory of these rooms discloses a general paucity of personal belongings, essential furniture, photographs, wall decorations and personal talismans. It is here that the greatest number of restraining "half-doors" are found (See Figure 4). These patient rooms most closely fit expectations of an institutional environment (See Figure 4).

The South Wing, or "intermediate care" wing, is characterized by a mid-range level of ability relative to other patients at Faxon Grove Manor. The patient rooms are relatively well-stocked with personal possessions but essential furniture and personal items and appliances are sparse. Talismans are in greater evidence but not well-ventured.

The East Wing, or "light care" wing (also "rehabilitative wing"), reflects the relatively high level of functioning retained by these patients. In this wing, the greatest



FIGURE 4
HEAVY DUTY CONTAINER



FIGURE 3
PATIENT ROOM--BUILT CASE CORRIDOR

order of personal belongings, residential furniture, hand carts, and television sets are found. A television set is present in every patient's room and occasionally one room has two televisions (See Figure 1).

These patients with high levels of functioning are fully aware of the wing--ability relationship. The nursing staff in discussion may "illustrate" an ambulatory-wing patient into some behavior (typically some type of self health-care action) by simply mentioning the likelihood of being moved to the Intermediate care wing. Other staffed assistants assist, always with the power of the "threat" directed at movement toward the least desirable wing. There is very little voluntary contact with the heavy-care wing patients by members of the other wings, and the heavy-care wing is referred to as 'over on North where those pitiful people are' (cf. Gubrium 1975: 14, 21). Thus, wing assignment is a metaphor of one's functional capacity and proximity to death.

Establishment of one's position within the wing--ability system is decided at admission by the B.M. under the assistance administrator. Some availability may also influence the initial wing assignment. Regardless of actual placement, the cognitive map of relating to the entire experience of living and dying at Peace Grove Home is one of total submission to the ambulatory wing with a high-level functional capacity, followed by physical and mental decline resulting in a move to the Intermediate wing. From



FIGURE 4
PATIENT ROOM--OCCUPANCY VIEW

space. Further decision is experienced necessitating a move to the heavy-wing wing with the other "pitiful people," "poor things," and "crazy ones." Even within this wing, a final move through space signals impending death. The dying are moved to Room #1 North due to its proximity to the nurses' station. From here, the final move is final. The patient, then, learns to use this "knowledge" as a grid upon which to maintain a constant fix on his or her date with death.

The experience of Pease Grove Manor seems to be characteristic of American institutional settings for the aged. Pease Grove Manor as an institution conforms generally to Bennett's median level of institutional totality (Gompert and Rabreau 1981:47). However, Pease Grove Manor's three sections have certain institutional characteristics in common but also each wing requires its own special treatment. Institutional characteristics across all wings range from high to low levels of institutional totality. For example, the nursing home as a whole is a permanent residence (high level), socialization of new members is informal (median level), and there exists no objective sanction system (low level).

Again, using Bennett and Rabreau's (1981:47) scheme, the heavy-care wing has seven of ten criteria commensurate with a high level of institutional totality. The medium-care wing has only three of ten high-level characteristics, while the light-care wing has only one, that of permanent. With regard to a median level of institutional totality, the

heavy-duty wing has only one matching item, the intermediate-wing has seven out of ten matches. The Low mortality category has all three wings assigned to just one item— no objective situations. Overall, *Forma Group Natur* can be characterized as an institution with a medium level of consilacy. In this setting, persons play out their daily life cycles in association with some of employees hired to assist and monitor this final phase of existence.

1. In fact, on the 11 PM to 7 AM shift one night several years ago, the aides and myself were surprised to see a car drive from the highway down the parking house parking lot. A man came over the parking house, walked across the lobby to the nurses' station and asked for a room for the night.

CHAPTER FIVE
THE DAILY CYCLE RITUALS OF FANTASIZED LIFE

From Dawn Dawn is a society of elders experiencing life at imminent risk of death while their progress toward this end is monitored by paid attendants. However, the medical propensity for denial of death demands illusion to mask the cultural apparatus of lingering death. This theme is like the mesmerizing qualities of the magician's slight-of-hand that allows transcendence beyond the plane of modern experience into the specifying realm of reality denied. Thus, the fantasized reality of the nursing home is changed by a daily series of rituals fabricating the illusion of meaningfully transacted life.

The principal elements of nursing home life involve a triad of patients, nurses' aides, and care-giving personnel associated with chronic debilitating disease necessitating long-term care. Interactional exchanges between nurses' aides and patients are characterized by daily, continuous contact with each other. In this environment of long-term exposure to patients, the nurses' aides, though generally untrained, become highly sensitive to patients' typical behavioral patterns and willingly become discourses of exacerbated illness episodes who may trust or report their findings to licensed nursing personnel who then carry out a prescribed protocol. Also, patients are able to manipulate their hosts by exploiting cultural mechanisms of social control and identifying resources within the nursing home

community to assist than in supplanting institutional life and chronic disease.

The inner workings of nursing homes have been examined from a variety of perspectives, each with its own version of quality and degree of quality. Social scientists have long accused the nursing home industry of being obnoxious. Consider these titles: Tender Loving Care (Henderson 1974) Old Age: The Last Segregation (Thornwood 1971), Shame They Go to 12s: The Tyranny of America's Aged (Harvin and Tanager 1969), and The Old, The Blind, The Bad (Olsen and Reinhardt 1971).

Another category of nursing home specialists involves the experimental administrators teaching others to be order-keepers. These works are distinguished by manipulative marketing techniques designed to promote a nursing home (Duchene 1974) and "How to" instructions detailing how to do in politics and families (Rogers 1975; Miller 1965). Other nonscientifically explained volumes attempt to be more theoretically oriented (Pelham 1974, Brown and Turner 1974).

A shift in orientation of perspective is observed as the authors of works examining nursing homes are identifiable as social scientists. The content of such volumes tends to be oriented toward an analytical view of the inner workings of nursing home living and ideas regarding the quality of life of the inmates. Some comprehensive volumes include Long-Term Care (Thornwood 1970), Long-Term Care of Older People (Greely 1972), Long-Term Care for the Aged (Tobin

Lindemann 1934), and Wider Storm for the Old General,
 Wicks, and William 1917).

An irony of expatriation regarding aging and particu-
 larly aging in an institutional environment is that their
 memory efforts are done by young and middle-aged people.
 It would seem especially onerous for a nursing home patient
 to do and publish research on his or her own setting. In its
 here that the benefits of the anthropological data-gathering
 method of participant-observation coupled with systematic observations
 and recording are highlighted. While one may never become
 a member of another reality, participant-observation en-
 hances the depth of understanding and communication between
 the researcher and the community of study. In this research
 project, I was able to not only observe and record daily
 events, but also participate to the extent of being a con-
 stant of patients, a part-time paid employee of the nursing
 home, a participant of civil/religious in-house events, a
 cultural teacher for new patients and families, and a paid
 speaker for the state-wide nursing home association. Thus,
 not only did I observe the daily cycle, but was actually en-
 gaged in the fabrication of life.

The participants in institutional settings community-
 specific socialization patterns known as rituals of insti-
 tution which are further reinforced on occasion by
 rituals of solidarity. The objects of these socialization
 process are the people of the community. In order to
 properly delineate life in these home-based, the daily

participants were to be identified, their roles defined and assigned, and then this system put into action.

The members of this community can be classified into two general categories: managerial and target populations. The managerial group consists of the hierarchy of all paid staff groups and the target group consists of patients and their families. Implicit in this scheme is an organizational orientation characterized by managerial groups acting on target groups. The components of primary importance here are the nurses' side as a managerial subgroup and the patients as a target subgroup. Due to the enormous amount of time these two groups of people spend together engaged in interacting rituals of life.

The indoctrination of nurses' side into the ethos of the nursing home staff involves formal and informal socialization. Formally, the new side is taught how to identify behavior as a meeting with the R F. During which the patient is identified as most important and the administrator (i.e., Nurse) as least important. Even a document confirming the socialization of this ethos is signed by the new nurses' side and filed in her employment folder.

The informal socialization of the new nurses' side comes from the administrator and is based on the presumed responsibilities of patients, their families, and government inspectors. A common phrase which circulates among the administration at Cedar Grove reads characterizes the perception of the typical nurses' side: "Yes, white,

and forty." In fact, this phrase is fairly accurate. Most of the nurses' aides have not graduated from high school, are married or divorced, have children, have a history of working at a variety of unskilled jobs, and are overweight, white and middle-aged. Two other local industries predominant in the area than at Penn Green Manor. These industries, the manufacture of home trailers and the assembly of tractors, hire at minimum wage and offer assembly-line type tasks. Employment at Penn Green Manor is perceived by many as a step because one works in a higher-status setting with humanitarian goals and still is paid the federal minimum wage.

The administration, however, is confronted with a special task. While local women may aspire to employment at Penn Green Manor, once there, a transformation from a view of job goals as repetitive, quick action on insignificant objects to a view of job goals as repetitive, quick action on significant objects is required. The value of assembly line efficiency is retained, but there is a shift from machines to human as the task target.

The administration of Penn Green Manor fosters a pseudo-ethnocentric interactional orientation between nurses aides and patients. The effort is to anthropomorphize the targets of the aides' responsibilities. The ethnocentric preparation also makes use of values familiar to the new nurses' aide employee who typically has no professional training and a meager repertoire of rules on which

in his/her behavior is a nursing home setting. There exist many symbols to signify the mother role or "mothering" behaviors, including, housework, hair wash hair, diapers, etc. By focusing on the mother/child interactional pattern, a maximum level of care behavior is extracted from the untrained, low-level nurses' side.

The mother/child role relationship is expressed in a variety of ways. The infantilization of the adult patient can be observed in child-like words for excrement ("shoo-shoo," "pee-pee") and diapers ("diapers"). One instance I observed demonstrated the nursing staff used to persist in infantilizing the patient. A nurse was managing a male patient with a distended lower abdomen. The man had a history of prostateitis. The nurse used "pee" and "pee water" while the patient used "urinate" and "catch a special man."

Other expressions of infantilization are more explicitly explicit than referring to patients as "baby," "little one," or "little people." Consider these phrases:

"... just wash them like I would one of my own children, 'cause that's just what they are."

"I've got young kids and so I'm well suited to this job."

"Like babies, they get paid and worn and they pee up a storm."

"I think of these people as my babies, especially the ones on North Wing because they are so helpless."

"They're like children... They are there for us to spoil."

"They are like children and that's
the way I treat them."

While promotion of the mother/child role behavior may function to enhance caregiving and to protect the patients conceptually, there are also costs that accrue. For example, acting as a mother prevents a patient from eliciting the appropriate dyadic responses of a child. Adult-to-adult interaction is thus retarded.

Particularly lacking is adult/adult interaction among male patients and the female nursing staff. I found the men clearly less "man" talk. Male patients were the most embarrassed in their conversations when I sought advice about proper authorization as a trainee. Inquired about hunting, fishing, and trapping exploits, asked about farming or ranching and other "male domains." Conversational topics of this nature were absent during nurse/male patient interactions. Self-generated conversation of this nature was not common among the men due to daily familiarity of the nurses and possible exhaustion of topics. My presence and questions produced high-energy conversations due to my access to the nursing home, and my continued contact with the non-nursing home community, and a perception of self-worth in that they were being asked to share a part of their past role experiences with a younger man.

Administrative influences on nurses' roles is seen again in the distribution of the nursing staff in task and wing assignment. Staffing of each wing varies according to

the level of care needed and shift time. For instance, federal regulations require one nursing staff member per each ten patients on day shift (4 AM to 2:30 PM), one nursing staff member per each twenty patients on evening shift (2:30 PM to 11 PM) and one nursing staff member per each twenty-five patients on night shift (11 PM to 8:30 AM). Since Penn State Hospital is designed to accommodate twenty patients, the day shift has eight nurses' aides and one L.P.N., the evening shift has five aides and one L.P.N., and the night shift has three aides and one L.P.N.

The distribution of aides by shift is based on level of care needed on each wing. Pediatrics, obstetrics, cardiac ward, and three women's aides are the most active during the day shifts. Day shift nursing staff is the most differentiated. The long-term wing has four aides, the intermediate-care wing has three aides, and the ambulatory wing has one aide who, during part of the day shift, helps with beds and food delivery. The majority of the day shift she spends dividing her time between the other wings.

The day shift begins officially at 4:00 AM, but day shift aides have informally assembled in the lobby near the women's station for casual socializing ranging from 3:15 AM until shift report. Pre-shift conversations are typically about personal community life. Only if something unusual regarding a patient has occurred in the night of the nursing hour related.

Shift report begins about 5:30-5:35 AM. The day shift sides move to the nurses' station, having been summoned by the charge nurse (an L.P.N.) to review or listen to the events of the night even as significant. The content of the shift report includes those topics medications given, assessments made (e.g., vital signs), and unusual events or need changes.

Key shift-report information is available in the nurses' side. Medications given are read by name of drug, amount given and to whom it was given. After report, none of the sides were ever able to tell us what the medications were for or why they were given, with the exception of two cardiologists. Therazine and Sparine ("to keep them quiet"), Valium ("three pills"), and atropine ("heart pills"). Vital signs were seen as significant only if unusually exaggerated and emphasized by the charge nurse reading the report.

Shift-report information that elicited responses from the nurses' side was the mention of lassitude (often read as "lack of mag"), falls, escapes, and confusion. Lassitude and behavior problems were work for the sides. Reports of lassitude being given were met with such remarks as "Oh, well," "We'll be busy today," and "they don't need any lassitude!"

In spite of the extensive use of shift-report information, the entire previous-shift nursing activities were always reported. Rather than functioning ritualized,

however, shift-report serves an important purpose. It marks a transition from medical individualism and somewhat narrow medical beliefs; toward inspiring awe and respect for the medical and humanitarian tasks ahead. As one aide put it while making a bed: "I've always wanted to be in the world of medicine."

The duties of the nurses' aides are even in the most complete form on the day shift on the heavy-care wing. A typical evening for four nurses' aides is presented in Figure 7. This daily shift schedule collapses into seven work task categories plus miscellaneous work (See Figure 8).

The tasks requiring the most time per shift are feeding, bed sheet and showers. Feeding is time-consuming in that on the heavy-care wing, 80% of the patients eat in their rooms and of those, 70% require feeding by an aide.

At lunchtime, for example, there are four nurses' aides who pour milk and tea for each patient, place them on the trays, and take the trays to the patients. After all trays have been distributed, the four aides feed the eight patients who cannot otherwise eat. For the nurses' aides there are "feeders" (i.e., a patient requiring feeding) who are more desirable than others. Desirable features include a room furniture arrangement allowing (read=requiring) the aide to sit while feeding, a patient who does not shake, drink or otherwise "cause problems," and a patient who eats rapidly. Thus, following tray distribution, a silent race ensues among the aides to acquire the most desirable feeders.

ACTIVITY	TIME
Wights on	01:17 AM
License	01:30 - 01:00 AM
Get patients up	01:00 - 01:10 AM
Take beds	01:00 - 01:10 AM
Breakfast	01:30 - 01:01 AM
Get (back of) sides	01:01 - 01:10 AM
Shower (of sides)	01:01 - 01:10 AM
Shaving	01:10 - 01:11 AM
Break	01:10 - 01:10 AM
Shaving	01:10 - 01:10 AM
Lunch	01:17 - 01:10 PM
Get patients in bed	01:00 - 01:10 PM
Have dirty linen	01:00 - 01:10 PM
Admire lunch	01:17 - 01:17 PM
Shaving	01:17 - 01:17 PM
Talk, the whole	01:17 - 01:17 PM

WRIGHT AND TIME-TIME ACTIVITY

3 May 1970

(FOR AIMEE EXCEPT WRIGHT)

Figure 1

ACTIVITY	TIME DURATION
Swimming up, down, or circling	1 hour 32 minutes
Food service	2 hours 32 minutes
Get drink, make beds, clean beds	2 hours 24 minutes
Diving	2 hours 18 minutes
Break, lunch	45 minutes
Sleep	20 minutes
Shower	2 hours 48 minutes
Miscellaneous (includes dirty items for the sink)	15 minutes
	8 hours 18 minutes*

*For those operators' slides who don't give the showers

WORKER' AID TIME-TIME CATEGORIES

3 May 1978

Figure 1

When I began working on a paid nurses' side, the first striking discovery I made was that each side has accumulated a large array of personal habits of each patient that rendered their service to the patient more personal and time-efficient (cf. Taylor 1903). For instance, the placement of a juice glass on the left side of a breakfast tray for one person renders the glass more visible and accessible, two packages of sugar for one person, three for another, no napkin for that person because they use paper, etc., is required for proper job performance. The caring of individual patient wants is accurate and generally fulfilled fairly lengthy, daily contact would make such a task possible.

This same intimate knowledge of patients is observed in writing behavioral change that may be of medical consequence. Actual hands-on contact with patients such as feeding, bathing, clothing, changing diapers and bed linens, provides the nurses' side with another set of information. The nurses' side becomes aware by their repetition of patient-specific behavioral patterns and principles. Earlier than from an expected set of behavioral norms, nurses move to a higher authority.

For example, Mr. Patrick Henry (pseudonym) is a white male, 72 years old, bed-fast, diabetic, paralyzed on his right side as a result of a cerebral vascular accident, incontinent and requires feeding. The position of Mr. Henry's bed is such that the nurses' side continuously feed him from one side of the bed. For weeks this was satisfactory until one morning a nurses' side reported to the

when aides that Mr. Henry started to be drinking very slightly from the left corner of his mouth. I later told Mr. Henry and found the report accurate. The loss of food from his mouth was slight enough so that only the staff who worked with this patient routinely day-in-and-day-out would recognize this as a potentially significant behavioral change. Without extensive monitoring of Mr. Henry's behavior patterns, the drinking may have been attributed to his position in bed, soft diet, dislike of the taste, or as just another patient who drinks. This change was reported to the R.S. as evidence of a state stroke. The aide who reported the change later told the group that the R.S. attributed the change not to stroke, but to his medication which included large quantities of Thorazine. However, Mr. Henry's chart recorded no change in medication before or after the aide's report.

The nurses' aides, in spite of no medical training, are the most important health-care agents in Room Seven House. Their significance exists in their extensive contact with the patients. They may be able to identify an important change in a patient that the R.S. would be unable to do. The aide who notices some relevant change recounts her story for several days until virtually all the staff is aware of it. Thus, the lack of training and low status of the current aide is not necessarily a detriment to patient well-being.

Remaining slight changes in patients leads the nurses' aides to engage in a variety of folk-diagnoses and prescriptions, for they know what their patients mean. A frequent diagnosis is constipation. This does not require modification of the R.R. or intensive nursing symptoms persist. The symptoms are subtle ones such as patients who look like they are straining when they should be relaxed or had a patient exploring his nose with a somewhat determined facial expression, general facial mood, and deviation from expected then intervals of level movements.

If it is determined that the patient suffers from constipation the care is to reserve a suspected lower rectal inspection. This involves a trip to the nurses' station, determines off-limits to the average staff to get a surgical glove and use "R" jelly. The patient is often positioned in front of a toilet in expectation of successful therapy. If an inspection is proven and reserved and the allstage action produces a bowel movement, or even if the blockage is up higher and not completely relieved, the diagnosis and therapy still allows the nurses' aides a brief "every body" "wellness" and some reassurance for themselves that it will be some time before they have to change their patient's underwear or diaper.

Other folk-diagnoses made by nurses' aides involve about observed changes in the integument. Tasks assigned to the nurses' aides require seeing and touching the patients' skin. Feeding, bathing, cleaning incontinence and clothing

a patient provides ample opportunity for close, sustained contact with individual prisoners. This "hands-on" contact promotes situations in which the nurses' aides are the initial agents of health-care providing.

Abnormal body temperature is susceptible to nurses' aide detection. However, since all thermometers are kept at the nurses' station, the nurses' aide is a patient's first line of contact of past experience with a patient to determine abnormal temperature. The ability to perceive fever by a nurses' aide requires long-term contact with each patient. Several reasons exist for this prerequisite. Each person has individual responses for body temperature adjustment, air temperature in each room is variable, blankets and clothing alter skin temperatures, and rather than sheets, plastic-covered mattresses, or plastic coverings as may be present which could cause skin temperature increases. Thus, the person may typically come enough to thoroughly inspect bed linens while checking a normal temperature.

If a patient is suspected of having an abnormal body temperature, the nurses' aide goes to the nurses' station to get a sterile thermometer and "E-T" jelly of rectal temperature is taken. Not only does this allow the nurses' aide to engage in "medical therapy" for a brief time, but it is a legitimate time-consuming way from the mere random, "strip work" which is the common lot of nurses' aides.

ECG/heart changes are also noted for acute hypertension. Noting of the face is a primary symptom nurses'

nurse can to diagnose hypertension. As able she is trained to measure blood pressure just as the nurse's station for a sphygmomanometer and sphygmomanometer. If hypertension is indicated, the nurse's aide will report it to the nurse's station with or report if the charge nurse is away or actually mentioned as a negative result to the charge nurse if present.

Perhaps the most important skin signs observed by the nurse's aide is the pruritus leading to decubitus ulcers. Reddened skin, particularly on regions of heavy prominence, is a signal of impending bedsores. Bedsores are particular problems for long-term care hospitals and those who sit in wheelchairs or even lounge chairs for lengthy periods of time.

When reddened skin is noticed, it is desirable to massage the local area with lotion. However, this simple preventive measure is infrequently used. The technique of simple massage lacks the paraphrase which signals high-level medical therapy. Also, lotions that are frequently used are purchased by the patient or the patient's family and are thus generally unavailable for even distribution throughout the patient population. As a result, decubitus ulcers are present.

The presence of decubitus ulcers is an embarrassment to the nursing staff. The nursing staff often blame the existence of decubitus ulcers on mismanagement of patients while they were away at a hospital. These hospital-patients

and behaviors are then transferred to the nursing home. While this may be true to some extent, behavior laboratory originates in the nursing home. Yet, the nursing director that "behaviors are totally premeditated" seems to be overly optimistic. People who are kept alive for as long that they can't be handled because they know in the skin where you can hardly be expected to remain free of disturbing ideas. Likewise, the constant geriatric patient who is incontinent and fed by a nurse (patient like representative another nearly impossible task in describing other management. It remains true, however, that more effort is expended in behavior management than prevention.

Also involved in the primary of physical care is that it is expressed in physical activity. The busy side is one who is working. The charge nurse can look down the corridor and tell if the sides are actually working by the movement in and out of rooms. The sides coordinate this degree rather completely and probably by transfer from other jobs. For instance, I noticed one nurse's side leaning on a patient's bedrail and talking to the patient for about five minutes. Later, in response to my question of what she had been doing, I was told, "Just foolin' around."

Physical evaluation of patient care is further prompted by the observability, immediacy of results, and amenability to rapid dispensing. Thus, the nurse's side can present the good-worker image not only by activity, but by the physical proof of busy performance within the time associations of her shifts.

Perhaps the task most associated with nurses' aides' duties is "bed check." By federal regulation, all noncontinent-limited patients must be routinely checked for incontinent bed check than consists of visual or physical inspection of incontinent patients. Soiled clothing, bed linens, bed frames and patients must be changed or cleaned.

Subtask C1935 refers to this part of nurses' aides' duties as "bed and body" work. It is this task category that most undermines the patients' and nurses' aides' sense of propriety. Bed and body work poses very the violation of one's daily "et" to reveal the "underside" of a lifetime of culturally appropriate Depression management. The locked door that screens the toilet habits occurring in the American bathroom (cf. Silver 1986) is ripped from its hinges for both the patients and nurses' aides.

Bed check is considered the most socially and physically taxing job task. One's performance here tends to post ranking along a continuum of good to bad. The stresses involved for aides and patients in bed check are common and are expressed in the following vignette from my participant's and observations:

'Now you're really gonna get broken in,' the female nurses' aide told me as I approached Mr. Joe Green's (pseudonym) room. Mr. Green lay in his nursing home bed in a non-verbal state of incontinence. He is a diabetic, an alcoholic, an amputee, a hemiplegic from an old cerebrovascular accident, a non-verbal, deaf and possibly considered to be ill-equipped. As he lies in bed, Mr. Green often tells us 12 story police stories.

twirly motion like

Mr. Green lay on his back, his head on pillows and the strap of his left leg compressed at the distal end of the lower) supported on pillows & plastic vertical in left between his legs with his penis positioned inside. The first task of the aide is to empty the urinary. Sometimes the plastic rests on the side of the dry urinary, other times it is submerged in urine. In either case, the urinary is removed by waving it away from the body. As the penis exits the urinary, it drags along the inside surface of the urinary eliciting a painful cry or a stream of expletives. Only once was it observed that an aide positioned Mr. Green's penis so that it didn't scrape against the surface of the urinary.

As Mr. Green is rolled toward the side of the bed, a liquid pool of feces between his legs and is filled with decomposable bits of food. The aide usually vomits. The aide loudly" threatens Mr. Green and begins to clean him.

The buttocks are spread and the corner of a Green protective panel is used to begin cleaning. After the majority of fecal matter is removed, washcloths are used to finish the job. Invariably, Mr. Green screams as the aides that they are hurting him as they clean the various folds down as with attempt to touch the scrotum in an effort to agitate the urethra and thermoplastic of cleaning.

Sometimes, a shower is required to clean Mr. Green from incontinence. In this instance, he may be wrapped in the bed sheets and placed in a shower chair so he could be the shower. At other times, when the floor and clean chairs are not in such jeopardy, he is placed in the shower chair naked and then covered with a sheet immediately to transport. At these times, he is apt to loudly complain that "how off we are up there!" The aides generally scold him and try to restrain him.

Distraction with Mr. Green typically requires the services of three aides. Two he lifts and cleans and one to hold Mr. Green's hands to prevent him from striking

those in reach. While Mr. Green is modestly alert, conversational, and likes to talk about his former flying days, conversation is directed toward Mr. Green's reactions who cannot speak at all. The woman is 26 years old, usually unaided behavior is a child-like manner including delight with toys and stuffed animals.

A number of episodes between patients and nurses' aides was observed in the above interaction. Observing the procedures for cleaning incontinence or reading about it does little to deny the actual, hourly, daily importance.

Mr. Frank Dave Baker, the nurses' aide "man" from official, administrative and nursing division, "love" all of the "little old people," do their jobs with great efficiency and show all, never, ever disrespect a patient. From a managerial perspective, regarding these experienced qualities will not insure perfection of job performance, but will enhance the likelihood of good patient care. Acting out these exhortations with patients like Mr. Green is difficult.

In spite of acknowledgments and reports of "loving all these little old people," occasionally more honest statements emerged. "We love all of these little old people, but we love some more than others." Thus, the good patient/bad patient distinction commonly observed in other health care settings is found here, see (cf. Lofner, 1973, van Marck and Barley, 1980).

Mr. Green is considered a "bad" patient. Incontinence or other disability alone is not enough to warrant bad-patient status. These traits, however, are prototypical bad-patient

status in some combination with the following conditions: some degree of mental intactness, physical strength, speech, and vocal compliance.

Another obstacle to case selection from sexual abuse only came did a nurse's wife teach Mr. Green's peers to English in the school. Mr. Green's situation often was left with some facial material on it due to incomplete cleaning. Other male patients who were not circumcised never, in my observations, had the foreskin retracted for thorough cleaning of the glans. On the other hand, I was allowed to assist in collecting babies with a twenty-five year old, mostly retarded female except when she was menstruating.

Lastly, the nurses' aides misbehaved sometimes with Mr. Green by avoiding all but essential communications. Mr. Green's roommates, even though he was apathetic, was the recipient of generous amounts of conversation to which he would laugh, not stop, and make "goo-goo" noises, delighting the nurses' aides.

In Mr. Green's case one of a difficult period of a difficult shift. I personally experienced working with Mr. Green very dissatisfying. He did well, laugh, and say badly however, when I had the time to ask him about his life, he was responsive and I was surprised to find a rather complete, intact personality. This did not elicit in me a missionary zeal of saving this man's soul. My willingness to talk with Mr. Green was only produced because

time had identified me as a resource (perhaps "my work" should be ready for him. He then would shoot from his bed for me by name to give him a signature. A patient asking to bed requires the aide to stay in the room and thus interfere with the work schedule. At times I would simply end at other times I was unable to do as due to work demands.

Actions other than physical ones directed at patients involve efforts at promoting psychosocial support for the patient population. The psychosocial environment is expected to be shaped by that part of the nursing team left known as "nurses' aides" stationed at Room Care Ward and frequent and of variable quality (See Figure 8). Three features of the clinical situation deserve mention: (1) nurses' aides' behaviorism, (2) lack of response measurement, and (3) observation.

The nurses' aides represented interference in effective activity programs, primarily with regard to the weekly social in-house activities. For example, the "hand" activity consists of the activities director standing around patients in the east wing lobby to play various percussion instruments. She complained often that by the time she walked a few patients to the wash lobby and went down the corridors to get others and walk them back to the lobby, the early arrivals had become bored and wandered off to different parts of the building. Efforts to enlist the assistance of nurses' aides were futile due to the aides'

CATEGORY OF EVENT	PUBLIC INVOLVEMENT	SPONSORED/ FOLLOWED	CYCLE
Religious Services	X		WEEKLY
Special Religious Celebrations			
1 Christmas	X		ANNUAL
2 Easter	X		ANNUAL
Civil/Religious Celebrations			
1 Valentine's Day	X	X	ANNUAL
2 St. Patrick's Day	X	X	ANNUAL
3 Mother's Day	X		ANNUAL
4 Father's Day	X		ANNUAL
5 4th of July	X		ANNUAL
6 Halloween	X		ANNUAL
7 Thanksgiving	X		ANNUAL
Regular Activities:			
1 Birthdays		X	WEEKLY
2 Bingo		X	WEEKLY
3 Beauty Shop		X	WEEKLY
4 Crafts		X	WEEKLY
5 Sewing class		X	WEEKLY
6 Book		X	WEEKLY

ACTIVITIES

Figure 8

insistence that they did not have time, or could not leave "the lights" unattended.

The beauty shop is an activity that sometimes becomes a spontaneous party, even attracting male patients and office workers to the door. One L.P.N. disliked the laughing and conversation in the beauty shop because it disrupted the sanctuary-like environment she considered proper. As she told us one day, she preferred to work on chairs in the evening and night hours because families were less present, most patients were asleep, and she could engage in "private quality nursing care." One of those involved in activities suggested that the nurses' aides disliked patients in the beauty shop in the afternoon hours because it prevented the aides from putting the patients to bed as the aides "wouldn't have anything to do."

Activities as therapy are suspect, too, because there are no assessments of improvement in patients attributable to the activity program. Benefits to patients may be slight, subtle, or nonexistent, but no one knows for certain. The visibility of physical care benefits overshadows the relative invisibility of psychosocial improvement.

Activities in the religious and civil/traditions categories are highly visible and receive great attention from the administrative, nursing, and activities staffs. Most important is Christmas and Mother's Day. For example, the Mother's Day celebration became a community cooperative project in which conspicuous consumption brings status to the nursing home from the community.

Mother's Day 1978 lasted about three hours. It cost Pease Grove Manor \$217.30. Newspapers and radio/television cost \$100. One nearly full-page ad outlined a "morning TV's theme with a skirt, play, snow-cone stand, and antique cars parked near the highway." A competing morning show seven miles away combined with a smaller ad announcing a new genealogist on staff and a "passionful visitation on Mother's Day."

Pease Grove Manor spent \$84.30 on table linen, \$120 on a band, \$94.90 on flowers, \$121 on costumes, and \$44.74 on photographs, and more on miscellaneous items. Salaries of patients, employees and nonemployees totaled between \$80 and 150 apiece. Patients, staff and visitors all appeared to enjoy themselves. Within a few weeks, reminiscing about the party had ceased.

One month before the Mother's Day event, a group of patients were involved in an activity that they still mention over one year later. Nearby Pease Grove Manor is a large lake with many recreational potentials. The activities director decided to arrange a fishing trip to a floating, enclosed fishing dock. The intent of the float is arranged so people can sit and fish in any type of weather. Complete services are available, ranging from a bait house and equipment rental, to a cafe.

Seven calls previously were declined to go on this trip. Selection was based on level of ability, behavior, and an expressed desire to go. Three men from the community were

asked to help at the fishing pier. They were expected to assist in building boats, mending fish, and any other fish-related tasks. They were invited to fish, too. The remainder of the party consisted of the activities director and myself.

Twelve people participated in the outing for a seat to the nursing home of SFLFL. The five-hour event took place on a Tuesday from 9 AM to 3 PM. The activities director sent a mail note-up to the local weekly newspaper as to monthly date with patients' birthdays. Other than this, the community-at-large was undisturbed and unaware of the fishing trip.

The affect of the trip on the patients and the activities director was quite noticeable. Patients were ready to go and positioned at the entrance doors 30 to 45 minutes in advance. Although everyone was ready for a rush at the end of the trip, the patients asked when they could go again. The activities director considered possible ways to continue such trips by buying some small baited rods-and-reels and some fishing tackle. A member of the administrative staff mentioned that the group of people wanting to go would increase in size. Overall, I had never seen these particular men so motivated prior to the trip or known of a special activity that engendered such a sustained level of excitement and anticipation of another trip.

Walter's Bay and the fishing trip were both entered on government forms as activities. Nonetheless, such events

served different purposes which led to the retention of some of the event. The Mother's Day events and other major occasions are opportunities to symbolically, though indirectly, remember to the public Frank Grove Hunter's solid concern for the welfare of their patients. The more visible and lavish this public event is, the more status is given to the nursing home, and its reputation is elevated or improved. Conversely, the fishing trip was a low visibility, uncompetitive event affecting fewer patients. There is great opportunity for quality psycho-social improvement (judging by change in their affective mood) and enrichment but little chance for status enhancement like nursing home Mother's Day will continue to be celebrated annually as part of the major public occasions. Over a year later the fishing trip has not been repeated although the men participants still reminisce about it.

The overall orientation toward patients in Frank Grove Hunter is one of palliative care. The presence of the medical model is expressed in ritualistic monitoring of patient decline. As physical or occupational therapist is possessed. Although a physician R. H. is not required, Frank Grove Hunter knows one who is present during part of the day shift, five to six days per week (however, on-call twenty-four hours daily), and functions primarily as a nursing staff coordinator and takes representation of "high level" medical status to attract and manage patients and families. Other personnel involved in activities for patients supportive of

psychosocial relationships report difficulty getting assistance from nurses' aides and a perceived low status with the hierarchy of service providers.

This milieu is not conducive to maximizing the remaining potentials of the patients. Unlike palliative care units in acute-care hospitals (cf. Buckingham, *et al.* 1980), this nursing home and likely most others, make the members specific involvement with a history of rituals designed to create illusions of life for the patients, families, and staff.

It is clear that the patients' corner (cf. Smith 1980) is most directly influenced by that segment of the nursing staff known as the nurses' aides. The style of care-giving is one in which physical care is emphasized to the neglect of psychosocial care. Several reasons exist for this strategy. The nursing staff representative are trained in the traditional medical model as L.P.N.'s or R.N.'s. Their training emphasizes physical therapy with only a slight orientation toward psychosocial parameters. Federal inspection by Title 19 requirements clearly promotes and rewards medical action. For example, Francis House Nurses prides itself on having patients charts up-to-date meaning that all entries had been made on a daily basis, particularly daily remarks regarding each patient. "Charting" consumes the vast majority of the L.P.N.'s time. This practice becomes so performative, however, that patients who are away visiting or in the hospital have been unintentionally charted as not only pre-

ment, but the recipient of 'usual & & care' or 'up and about, cheerful' (cf. Roberts 1973). Still, the nursing home must meet the demands of federal government regulations.

The nurses' aide/patient/long-term care institutional environment operates collectively in providing a community of daily forced-interaction. The longevity of patient/nurses' aide interaction coupled with a mother-child interactional pattern leads to in-depth knowledge of patient behaviors. The nurses' aides being generally uneducated, rely on of their own physical actions and beliefs about health and disease to make decisions regarding therapeutic actions.

Psychosocial care is de-emphasized due to the pressures of fulfilling physical care needs. Best Department, however, is the relative invisibility of psychosocial care procedures and benefits. Additionally, benefits that accrue are likely to be relatively grossed in appearance. Lastly, there is no staff member who is trained to be perceptive of the psychosocial environment, while conversely there are plenty of staff members who have received formal education in business management and medical-model nursing. These factors are reflected in the topics for in-service training (see Figure 100).

The foregoing material describes a social system oriented toward long-term palliative health care performed by "unskilled nurses" aides on "institutionalized aged patients." A number of tensions between aides and patients have been identified with resolutions couched in no evidence of strategies particular to long-term care environment.

WISDOM TEETH IT	PERIODIC CARE A PATIENT RECEIVED	PERIODONTAL DISEASE	EXTRACTED PERIODONTAL DISEASE	PERIODONTAL DISEASE RECEIVED	TOTAL
1. 1. 1. 1. 1. 1.	1. 1.	1.	1.	1.	1.
PERIODONTAL	1.	1.	1.	1.	1.
PERIODONTAL	1.	1.	1.	1.	1.
TOTAL	1. 1.	1.	1.	1.	1. 1.

PERIODONTAL DISEASE TRENDS

Periods 1977 - July 1978

Figure 10

"Nurse" maid and patients alike have an extremely difficult task. The patient never ceases to pretend to be socially functional while being totally dependent. She is the victim of chronic disease and social circumstances. The nurse's wife, dressed in white, pretends to be therapeutically functional while dispensing palliative care. She is the victim of therapeutic expectations and inevitable disease. Thus, nurse and patient engage in a variety of rituals to fabricate a facsimile of life. In this way the stark reality of chronic disease and old age can be partly veiled.

Orientation toward patients at Haven Green Manor is remarkably similar to Julia Henry's (1943: 434) summary of the humane Tower Nursing Home:

An effort is developed to "nationalize" the Tower and the following: the staff, though untrained by education and intelligence seems to maintain an attitude of indulgent superiority to the patients whom they consider "backward" children, in need of care. The whole intention is to be brushed off, while their bodily needs are unobtrusively looked after. There is attention toward body and not toward mind. The mind of the patients gets in the way of the real business of the institution, which is medical care, feeding, and dressing. Anything national that the patient wants is given him as quickly as possible in the best disguise of duty, and harsh words are said at the same time the staff seems to have a total understanding of the mental characteristics of all mind groups.

CHAPTER 102
THE PATIENT EXPERIENCE THE NEXT BEST THING TO HOME

Perhaps the most critical issue in the experiential reality of institutionalized Person Grove Manor involves eliciting response from the patients themselves. On a daily basis, the patients must negotiate the entire social system of Person Grove Manor. The exclamation of working home life that seemingly are "no-problem" to the staff, families, and themselves, is for the most part, problems to the patients who must as resourcefully as possible manage their lives in this environment. Self-management is an institution because an supervisor can be family but in the identification and maximization of situationally-specific behavioral resources from a major resource pool.

Working home life involves institutionally-imposed constraints. Nonetheless, there exists sufficient tolerance to "black" in the formal normative system for behavioral flexibility or creativity to emerge. Thus, the patient population can be seen to experience expressive internal systems while simultaneously engaging in the creative attraction of self-transferring behavioral procedures.

The capacity for ingenuity within a geriatric population is apparently a point of dispute. In one recent treatise on aging (Blanchard and Warren 1975) dramatically opposed statements are found:

The depressing one goes from . . .
environments in which aged persons live
as well as from that which is written to

describe such experiments suggest the existence of a simplified seeing that was in factually ascertainable. This is easily an erroneous view of any. Both common sense and empirical data . . . demonstrate that seeing adaptability is fluid. (Grossman 1973:215)

Old people are remarkably adaptable. Silver tells a story about an experience he had while doing research on visual perception . . . One of the volunteers for the project was a man of around 65 years old who was active in the home and a leader in the activities there. He was well known by most of the residents and well liked. When Silver tested this man for visual ability he found that the old man was functionally blind. Silver went to the nursing-home administrator and asked if the administrator knew that Mr. X was blind. The administrator aside's believe Silver. Observing the old man's behavior very carefully, Silver found that the man was always accompanied by his wife, and she very subtly guided him and gave him cues as to what, although this man was functionally blind, not even the nursing home staff were aware of it. This remarkable example supports the adaptability of old people. (Grossman 1973:194)

The attainment of patient reorientation involves direct observation and questioning of the patient population. Recently, assessments of personal nursing home living experiments have found patient data not in sociodemographic variables or in objective physiological variables but in subjective perceptions of the inmates about their membership in an institution (Boatner and Karel 1944). Therefore, much important data about the institutional system comes directly from the patients themselves.

Twenty-three patients at Faxon Grove Manor were identified as especially helpful by my personal assessment and

their scoring on the Mental Status Questionnaire (Gale, et al., 1966) at the time of interview. All but one were subacute. The term "residence" is often used in gerontological literature when referring to institutionalized people with the greatest amount of ability. However, in this community of elderly people, all of the non-staff are considered and called "patients." They are sleep patients with a lesser dependence on help from the nurses' aides. Still, they are medicated, monitored, required to see a physician weekly, have call-lights in their rooms, and their bowel movements are daily checked. Their distinction from others lies within channels. The devotional combination of relatively limited mental and locomotor function provides them with the ability to utilize their remaining capacities.

In anthropological terms, these people are best able to undergo the psychological, behavioral, and sometimes physical restrictions of adjustment to a new environment. Over time, these adjustments become routinized as adaptive responses enabling the patient to maximize their chances of a successful "fit" within the community of which they are a part.

The purpose here is to examine the mechanisms of adaptation to a nursing home environment by a subgroup of the patient population. All twenty-three patients included in a structured interview. The average age of this sample is 82 years and 8 months with an average educational exposure

once leaving seven-and-a-half years. Seven are males and six are females. All of their respective spouses are dead. Peter is institutionalized, Ed lived alone, EPI lived with a relative, and AI lived with a spouse. Members of this sample had an average of ten-and-a-half visitors per month (mostly by relatives) with the last visit four-and-a-half days before the time of interview. Seven changes had occurred for EPI of them. Of these, the average number of changes approached two. They had lived at Fagan Grove Manor for an average of three years (upper range: eleven years, lower range: one month, mode: one year).

In all instances, environmental adaptations involve food procurement. In Fagan Grove Manor, prospective patients and their families are given information about dining that conveys a feeling of the greatest simplicity of getting food. There is a convenient distribution and a Salinas kitchen staff to provide complete food service three times daily. All the patient has to do is show up.

The patient, however, discovers otherwise. In with any new environment, there are certain ways to move efficiently in negotiating the system to maintain one's level of satisfaction. As is in with food procurement at Fagan Grove Manor.

The obligatory dining-room patients have developed food procurement strategies. The kitchen staff's view is that they put the food out and all the patients had to do is come eat. However, the patients' plans of satisfaction

differs from the kitchen staff in terms of corridor life and concepts of time and space. That, for the patients, constitutes frequent spatial planning.

Meals are never served at exactly the same time. The variance ranges from fifteen to thirty minutes and is due to random human factors and differing preparation times for various foods. Meals are usually served between 11.30 A.M. and 12.00 Noon. Also, patient trays are distributed by rotating the starting place of distribution. If at breakfast the first trays were placed at the west end of the dining room, at lunch they will begin at the east and distribution time from one end to the other is about thirty minutes.

The patient's goal is to estimate his or her time of arrival at the assigned table with the arrival of the food tray. If timing is correct, hot food will be hot and cold food will be cold. Patients begin leaving their rooms from 11.15 A.M. to 12.00 A.M. to walk or roll to the lobby or entrance area. There they will wait and sometimes talk with others nearby. In this 'war situation' patients continually glance toward the dining room which they can now see to notice the earliest activity from the kitchen. One signal used by many people is the appearance of a kitchen staff member who turns on the dining room light. Tray distribution begins at one end of the dining room. Those who sit at that end walk the now short distance to their

may immediately. Those who sit at the apparatus and typewelly wait until it is clear to the idea their own long review.

Thus, the necessity of moving is experienced differently by the staff and the patients. The administrative and kitchen staffs experience feeding as "food service" the patients population experiences feeding as "food presentation" with a history of etiologic behaviors necessary to adopt their physical symptoms to the physical environment.

The necessity of Papan Grove Home seems to require personal working beyond the brick-and-mortar edifice. The most common and consistently elicited report was that living at Papan Grove Home is neither ideal nor desirable but it is "the next best thing to home" given their circumstances. Moving home life is viewed by the patients as the only reasonable solution to their predicament of unemployment and chronic illness. The typical patient often regrets that no other supportive resources system is available to meet essential needs for physical well-being. For those having children who represent potential caretakers, the children are reported as willing to take them but the patient will not "bother" their children or "get in the way." Thus, the patients view the moving home as a resource rather than a place of confinement.

I'd rather be here than with my kids
 in ultimate personal conflict with
 them (unexpressed, 77 year old female)

If they can't get up and get around,
 call "in is good in (in Fagan Grove
 Manor). (77 year old male)

It's a good place to live, but there's
 no place like home (80 year old male)

Want living in home but it ain't home
 (80 year old male)

If you can't live at home, this is
 next. (78 year old male)

It's more like home than if I was with
 my children. I'd feel in the way if
 I was with my children and I don't feel
 in the way here (84 year old female)

They (her grandchildren) have no use
 for old people. Don't you know that?
 (88 year old female)

Responses to "What do you like most about living
 here at Fagan Grove Manor?" centered along privacy/staff
 dependency. The primary benefit is the security of having
 one's needs consistently met within a supportive set of
 perceived personal risks of simply being alone. The needs
 were clearly historical: companionship of staff and other
 patients, food service, and perceived medical-care avail-
 ability. Responses to "What do you like least about living
 here at Fagan Grove Manor?" were oriented toward situation-
 specific issues rather than the nursing home itself: separa-
 tion from family and friends and disordered behavior of
 other patients (eg, urinal, noisy)

Responses to what these patients missed most about
 their life prior to being institutionalized were

independent of the institution. The predominant response was a loss of personal independence coupled with the loss of their spouse. On the other hand, there was a significant improvement as a result of institutionalization. The presence of nurses' aides as helpers and being around other people for socializing were likewise reported as improvements in their lives.

The experience of being a nursing home patient actually begins before one enters the front door (Folkin and Liskowicz, 1984). The patient brings with him personally developed beliefs regarding nursing home life. Little is done to better precondition the prospective patient for admission to From Green House while in the hospital or at home prior to admission. Thus, early experiences in the nursing home can be unnecessarily traumatic. Consider the report (edited) of Mrs. Nancy Fipkin (paralyzed), a 75 year old, white female:

JOS: What kind of adjustment did you make? When you think back about when you first came here.

NP: Well, when I first came I was unhappy a little while. I didn't hardly know . . . me I just came out of the hospital here and I had had a nervous breakdown and I had a lot of adjusting to do anyway, wherever I had been. And then I just came out of it and I was just with and do anything I want to do. And I'm happy here.

JOS: What do you often meet about living in the community?

MP: Well, anybody's gonna have, but outside of that . . . But I miss home and Florida. But the friends come to see me and I see them so I just know that this is going to be my home from now on and I just accept it and try to make myself as happy. I don't have any complaints as far as myself is concerned. They are just as warm to me as they can be. Everything I've ever wanted anything, why, they're right, have to help me. I'm just . . . I'm just thrilled I've got a place like this to stay.

JMS: About how long do you remember it taking until you felt comfortable here? From the time you were first here.

MP: Oh, I guess it was six months before before I really could just come home and feel at home, but after that I was . . . But I was never miserable or confused. I . . . when I came I knew that this was going to be my home and I was going to make it pleasant as I could. So, I haven't let myself worry and think, "Why did I have to come here?" and "Why did this have to happen to me?" I've just accepted it and I've enjoyed it. I just work every old person that has to stay alone and be in danger of not being cared for you know. That's why I take care of themselves. It's a lot to have that feeling that you might.

JMS: Oh, how about some more on this too you're saying that you wished other people that would be here those kinds of services could have them. Could you think repeat that?

MP: Yeah, well I do. I wish that other people could see and know how happy we are in here. I don't think that it'll be . . . seemed like it . . . that I did, I had a time of getting down here. Before I came here, I'd heard things, you know, remember make. And I haven't found any of that or be true in my mind of what I'd heard or was afraid of.

JEN: What kind of things were those?

MR: Well, they just didn't take care of 'em and they'd let 'em lay in the yard and rot there, go over there 'em or they couldn't get nobody in there when they wanted 'em. Things like that, well, I've never had that.

WELL, I wish more people understood how we feel out here. And that we do have more out here. And do like I had, such a horror of coming. I just really, I did have a horror of coming out here. But after I got rich and Mr. F. came on and told me I'd have an even doing here and stay while, well I didn't say a word. I just thought, 'Well this I have to do.'

It's the best place outside of your own home that you would have to come to.

Now, consider the report (indirectly) of Mr. Frank Miller (pseudonym), a 75 year old, white male

FR: Well, for the last 10 or 15 years there's been a great improvement. A great one. I can remember my father and I went over to a person's opening home up there, were thinkin' about movin' my mother in there, and we changed our mind when we visited the opening home.

JEN: Why is that?

FR: Well, they made't run like they are now. So they old people think of a working home as a horrible place to go. They think it's just a dumpin' ground for -- Now, that the white and Southern people, well, it's run like a business more than it's ever been before. They've got to run right off else! else the share.

JEN: Are there this one all over that?

FR: It's a . . . I'd say neither way.

100. Number one?

101. It's like tape

102. 'Course Joe [100], I'll say when you can make up your mind to be satisfied with anything. Now people come here that's dissatisfied and don't want to come here. And people puts 'em in here and it takes 'em a long time to get, get satisfied. We've had one or two go over here that's just, oh, loved this place. And they like it, 'cause they know what it is. Because there old people. They thought about them old nursing homes years ago. I still think about 'em myself.

These comments regarding Farm Grove Manor should not be taken as actual evidence of a tension among home community. Describing the positive aspects of life at this nursing home are the expected and typical conflicts inherent among any group of people living in the community or an institution. What is significant, however, are the patients' denial of conflict and reluctance to talk about conflicts.

There exists an ethos of risk among the patients. Their lives are, in fact, daily at risk of worsening by having to leave the nursing home if they become not healthy, dealing with interpersonal conflict in a small environment, and deteriorating physically and mentally with death always on the horizon. Of the twenty-three older patients interviewed, twenty-two referred to the possibility of being dead in one year and all respondents said that they would be dead in five years.

Although leaving the nursing home to re-enter the community is rare (one wild stroke patient and one burn patient in the thirteen months of fieldwork) all patients receiving public funds must have a monthly physical examination by a physician. Most patients consider the physician to be a necessary nuisance to keep receiving their funds. The patients report the physician to be superficial and a means for the physician to make money. Skill, residence at public expense requires disability. The physical requirements a monthly potential for discharge.

Of more daily importance is the existence of open intergroup and intergroup conflict among patients and staff. The problems which are conflict-orientative are partly related to frustration of long-term care and partly related to characteristics of institutional living.

Membership in the institution is forced. There are no other viable options. The process of adjustment and incorporation into the institution develops a sense of personal investment in this community. Patients may on visits with relatives or during hospital stays speak of their desire to "get back home" to "sleep in my own bed." Thus, there is a desire to preserve their position in the nursing home.

Institutional characteristics that generate conflict-avoidance involve closed valued points upon. Open conflict is generative with a very limited institutional range is likely to be suppressed beyond winning. There is

conflict will constantly be near each other and have little option to retreat to quell hostilities due to reduced private space. Also in opposition to institutional public life expressed in the feeling that 'everyone will know my problems'.

One patient (68 year old female) stopped me in the hall one day finding it difficult to maintain eye contact and select her words. She eventually began with, "I know you know this already, . . ." I didn't. She related to a halting voice that she suspected her roommate of over-spiking with one of the cleaning women to put aluminum foil on the top part of the room windows. Her roommate is undoubtedly too weak and she is undoubtedly too cold. She said she didn't know whether or not this should be included in her story which she wanted to give me. They had earlier agreed to divide ownership of the window by the two panels of glass. Even in the winter, her roommate would exercise her ownership prerogative over her panel of glass by opening it, even though the window unit was not on "her side of the room."

This woman was convinced that the magnitude of this conflict was such that it was surely public knowledge. She also felt quite helpless in that the people (roommate and a staff member) had conspired against her. The perceived and real lack of physical and social resources caused a minor incident to have major implications for this patient.

Another male patient agreed to keep a diary to give us as he had then completed. Before he returned the unused diary to us, another patient told us that this man had bragged that he was "going to be a spy for Joe." When he returned it, he very obliquely stated that he was afraid that keeping the diary might cause trouble. In an environment that houses only a small pool of people, friendships are tenuous with which one should not tamper.

Other aspects of avoidance of open conflict exist in relation to long-term care. Not only would open conflict cause life to be difficult in close quarters, but one would experience a sustained level of tension because they will live there the rest of their lives. In acute-care hospitals, personal risk stemming from exposed information on hospital staff would not endure indefinitely. The experience of nursing home life is very much different.

At times, when complaints (though relatively innocuous) were voiced to us, I was typically told not to divulge the complainant's name to anyone. For example, comments about unsatisfactory meals were ended with "don't tell 'em I said that." I was told us that some folding chairs borrowed from a man's club had unintentionally been kept at the nursing home. His statement was almost totally obscured in disclaimers and caveats. The man's primary intent was to preserve a good relationship between the club and the nursing home. It was evident, however, that he didn't want to be perceived as a "trouble maker" for

the administration. Returning the chairs to the club would be more work for an already busy staff. Another lesbian involved a female patient who asked us to a quiet corner and asked us to move some lawn chairs back to their previous location so that they could be used as beds. I was then told not to tell anyone that she had made the request.

The reaction expressed by the patients regarding what seemed to us to be reasonable and direct items is produced by the knowledge that one will quite literally have to live with the not-totally-predictable consequences of one's actions. The public nature of life in an institution coupled with long term membership makes the otherwise inconsequential momentous.

The administrative staff also participates in conflict-aversion. The nurses' sides are told never to grow up or argue in the presence of patients. The patients are not to be bothered by personnel staff problems. The administrative staff believes that families and patients expect an idyllic paradise and the nursing home will produce what the customer wants.

It was my experience, however, that the patients shared the collection of my type. To overcome a nurse's own's actual personal problems was at the least harder than the rhetoric of feminism ever opens. Often patients interrupted comments regarded as too helpful in solving some dilemma. The patients felt more alive through

vicariously dealing with concrete life/situations when their own environment withstand them.

In fact, the nurses' aides are a virtual data bank for the patients to learn of community life and internal nursing home events. In spite of supervisory attempts to maintain nurses' aides' conversational topics, the aides are in intimate contact with patients for too great a time to totally prevent exchange of personal information.

Patients at Pease Grove Manor nursing home have also seized upon a naturally evolved element of their institutional setting as a personal resource. The housekeepers. The housekeepers at Pease Grove Manor are two women who visit nurses' aides at their working home prior to their employment as housekeepers. They routinely move through the hallways to separate, systematic rooms. Each housekeeper pushes a janitorial cart containing a mop, mop bucket with "sponges," trash bag, and numerous cleaners and disinfectants. The thoroughness of their work is attested to by the universal report from visitors and patients that Pease Grove Manor is "the cleanest nursing home I've ever seen."

In addition to their function as housekeepers, they represent an important resource to the patient population. They are brokers bridging the patients and the nursing staff especially with regard to sensitive issues and they are more available for conversational interaction than any other staff group.

Several factors are involved in the development of the dual role of the housekeeper. First, the potential for engaging minorities is greater with the housekeeper than with the mother's aides because domestic task assignments typically require longer periods of time for housekeepers. Because rapid break-out activities signals appropriate work notes for aides, the opposite is true for housekeepers.

Proper cleaning requires lengthy task performance processes. Thus, informal job-related maternal processes promote in-depth interaction between the parents and the housekeepers.

Emily Smith (housekeeper), one of the housekeepers, spoke of her dual role (defined):

EM: We'd be wondering why they (aides) come to visit with you all (housekeepers) so much.

EM: I think probably it's because maybe you're in the house longer and we can't meet while and they, they come (visit) to us. Because they'll tell us things maybe that they can't tell someone else.

EM: Because they talk to you and Maria (housekeeper, housekeeper) and they wouldn't talk to an aide?

EM: Well, ah, another reason. Yes. See, I've been here now for quite awhile, you know. And I worked as an aide so the mornings and I worked on the evenings and they, really, they feel like they have to listen then they do some of the other girls. And I think the same way as Maria because Maria has been out here a long time too, and a lot of these old

people were here when we were here. You know. And I don't know. I really don't know why, but they will. And Denise will probably tell you the same thing. They tell bad things that they won't tell the police or even their loved (sometimes, I.A.I., you know).

Jim: That sounds like in a way you all are more reliable ways to get to information in New Haven, CT. (sometimes, sometimes also)

Ed: And maybe another thing, I thought, well maybe they (sometimes) don't want to tell (in public), especially, and they (sometimes) know if they tell us then I will go tell if I think they CAN or I.P.M. I should know these things then I do go tell 'em, you know.

Well, sometimes, you know, well, I know. I never did feel like this but some of the aides think the housekeepers are just the housekeepers. You know. No, sometimes we understand the old people more than the nurses do.

Several subsidiary factors can be identified as antecedents of patient/housekeeper interaction. These seem to derive about personal characteristics of the housekeepers-- employment at Penn Grove Manor for a long time, previous work as an aide, wearing street clothes, and they are viewed as adults due to their middle-age status. These personal and job-related characteristics combine to produce a job and role category of great importance to institutionalized patients. The patients have identified and used the housekeeping staff category as an intranstitutional resource in an understood and unexpressed way. While the nurses come to the body, the housekeepers tend to the mind.

The patient population of Farm Street House, and particularly those most able patients, actively engage themselves in their community's activities. Their efforts are aimed at achieving identification and acceptance. These adaptive tasks are in constant motion due to the changing social environment and changes in their own personal capacity for negotiating shifts in physical and cognitive status. Thus, life on this nursing home is a physical and emotional challenge as was life in the non-institutionalized community.

Given chronic illness, unemployment, loss of spouse, and other common facts of the American "old age" experience, membership in a nursing home does not necessarily involve life without tension or challenge. The very nature of the American population's shifting home generates physical and emotional challenges to the patient population on a daily basis. This is not an argument against improvements in nursing homes but just the opposite. Recognition of the actually-existing resource pool allows for enhancement of patient life with little economic cost to the management. Observation and discussion among the patients will provide the routes to pre-established patient resources which can then be monitored, preserved, and enhanced.

CHAPTER SEVEN CHRONIC LIFE AND AGE DEGRADATION

Palliative-care settings, whether in hospitals or nursing homes, typically house people with chronic diseases and without expected recovery. The diseased state gradually strips the psychological essence of humanism until the host's life, in the fullest interactive sociocultural sense, is overshadowed by disease and debility. Disease becomes established as the prominent mode of existence and life now becomes the factor of chronicity. Disease is not the target of treatment, physical existence is. Thus, a condition of chronic life exists in the presence of debilitating disease which is permanent and persistent, rendering the diseased state more prominent than wellness and life, not disease, as the target of therapy.

Finally, modernization, as a societal process, comes with numerous attendant changes especially in technology and health technology (Houghlin and Palmer 1971, Congell 1974-1976). One result is increased longevity. For the very old, this is a dubious benefit (cf. Ellish 1978 70).

Many scholars distinguish between functional old age and nonfunctional old age (Simons 1940; Simons 1946; Clark and Anderson 1947). Functional old age can be considered aged life, while nonfunctional old age can be considered chronic life. Improvements in health care technology resulting in increased longevity also increases the risk of inducing chronic life in the aged population.

Clark and Anderson (1983:41) state, "The elderly have positions in our society because in other than as long as the these days." The affluence of chronic life, then, is indigenous in origin.

The cultural apparatus for dealing with chronic life takes various forms. Acute-care hospitals sometimes designate a section of the patient floors as palliative-care units. The hospice is typically an institution for the terminally ill that is separate from the hospital. However, nursing homes have been prominent as the standard American agency dealing with the historical problem of longevity and incapacitating incurable disease.

The ethnomethodological perspective was used in the study of Texas Green House nursing home. Special emphasis was devoted toward patients and paid care agents as significant role categories within the nursing home community. The ethnomethodological view identified patients, nurses' aides, and housekeepers as the international network most meaningfully associated with long-term care quality.

Within any community of people, differing points of view exist analytically as multiple realities (Berger 1969). This research has disclosed realities specific to various subgroups of people within the nursing home community. These realities characterize a category-specific arena.

The patient vision is marked by a pervasive sense of little life. The patients' view bounding her world is

own risk. Expulsion from the institution and life in the outside world. Patients adopt a fatalistic outlook regarding their membership in a nursing home population. Their control over their own destinies has been undermined by chronic disease, unemployment, and institutionalization. Therefore, they accept their lot not having expectations or resilience.

One form of adaptation is to selectively attend to the positive virtues of their current life and minimize the loss. Given the lack of better possibilities, patients report "their" nursing home is the best possible setting other than self-sufficient community life.

Conflict-avoidance serves to maintain the belief in the high quality of their situation by minimizing disruptive events. This procedure is encouraged by long-term institutional living. Additional pressure is leveled by the nursing and administration staffs to convey an aura of consensus in order to reduce family complaints and disputes. Although staff groups cover efforts to deny conflict, the patients' lifeline viewpoint perspectives ultimately result in psychological adaptation to the long-term institutional environment.

Patients also engage in conscious identification and exploitation within their community. The physical and psychosocial environments have been met as surmountable challenges rather than insurmountable challenges. Thus, food procurement strategies, social interaction, and

non-medical personnel care agents reflect the responsibilities of the geriatric nursing home patient.

Direct primary care from the "nurses" experience is the provision of nurses' aides and housekeepers. Nurses' aides constitute 47% of all staff categories in nursing homes nationwide (Department on Long-Term Care 1973:211) and 47% at Penn State Manor. From 1960-1974, the number of nurses' aides employed has increased by 22% (Giles and Schumacher 1973:21). The rapid rise in the number of nurses' aides is a product of the relatively recent biomedical culture embracing the American cultural value system emphasizing scientific and thus generating "scientific" work as nursing homes and the emergent (cf. Leach 1974) characteristic role of the nurses' aides.

While biomedical has changed the medical and public nursing aides, the increase in chronic irreversible disease has created a therapy and therapeutic vacuum. This vacuum is currently being filled by middle-aged women with little or no training engaging in therapy modeled after mother's child interactive patterns which are considered to be physically and emotionally nurturing. The response pattern of directing victims of chronic, irreversible disease to both medical practitioners rather than biomedical specialists was also found by Gould (1965) in rural North India.

Over the past two decades, the role of licensed nursing personnel has shifted from patient-contacts to

management as efforts at individual education and psychoanalysis have been pursued. The licensed nurse as mother-surrogate has declined (Schulman 1918-1972) to be replaced by the nurses' aide, particularly in nursing homes. The maternal approach to patient care in nursing by unlicensed personnel is not unique to the American long-term health care milieu. Gastil (1961), for example, describes the Japanese higashiki as an untrained female providing long-term basic care to psychiatric patients. The benefit of the higashiki is found in the use of the mother/child interactive pattern and long-term patient contact. As among the American nurses' aide, lack of formal training is compensated by surrogate kinship roles, a thorough familiarity of the patient (often remarried and affluent kin, Iida 1961), and use of folk therapies. Thus, the strict uniform, hospital-like environment, and other symbols of biomedical care serve only as a thin veil over the "Western" psychiatric folk therapist.

In summary, the nursing staff which is characterized by adult-onset nursing, holism and unlicensed nurses' aides play mother roles in the discharge of their duties with patients who are conceptually seen as children. Their work consists of bed-and-body-work to the near exclusion of psychosocial support of the patients. Pragmatically, mother/child interactional patterns mirror working behaviors from pre-existing role experiences of the generally unlicensed nurses' aides.

The nurses' aides through all of the reports of love for the patients essentially monitor patient decline. Their activities are viewed as necessary to make patients as comfortable as possible until they die. This view is consistent with a medical-model reflected toward caring as passive and lack of caring as failure. In order not to fail, there will be no attempt at therapy, only palliative care.

In Ferns Grove these care agents were found to include an unexpected category of providers, housekeepers. The biomedical view of health care organizations excludes housekeepers as therapeutic agents. The anthropological view, however, identifies the housekeeper as a socially evolved, unplanned agent of psychosocial support for patients.

Characteristics of the housekeepers' work, values regarding employment, and personal demeanor provide a field for ongoing interaction rather than relief, minimalistic interaction typical of nurses' aides. These characteristics include lengthy in-room task performance (by necessity and demonstration to supervisors of thoroughness of cleaning), wearing strict clothing, previous work as nurses' aides, and stable age status. Thus, the housekeeper is seen by the patient as an expected daily visitor who has extensive knowledge, every inflection throughout the nursing home, and reports on local community matters on a routine basis. Also patients use the housekeeper as a

worker in the transmittal of sensitive messages (e.g., complaints regarding the nursing staff) thereby distancing and insulating the patient from potential reprisals.

Collectively, these findings provide an example of the utility of the ethnomethodological orientation in examining "health care cultures" — the unplanned existence of spaces of psycho-social support in a nursing home in the form of候室 (waiting rooms) and the persistent depth of sympathy for human resources identification and care among institutionalized geriatric patients.

Overall, elderly Americans live a life of paradox. Millions fall victim to the heterogeneity-induced disease of chronic life. The technological milieu of modernization has increased longevity in the absence of sustained illness concomitantly generating respect for long-term survivors. The paradox for the compartmentalization of life is a breeding ground for reservation systems to contain certain segments of society.

Age-segregated communities are contained segments of society (Jacobs 1964; Angrosino 1978). Within one such community, the nursing home, the chronically-ill elderly are housed. At one level of abstraction, the outcomes of which they have been participants negotiators their lives by paid ritual-custodians. Within the social order, the survivors perform rituals fabricating signals of life which are designed to be in opposition to

culturally relevant negative emotions permeating deathbeds while actually inhibiting the final years of earthly life.

The medical model is directed to such a lofty spiritual plane (Siegel and Oswald 1974, Davis 1977) that a cure for the chronically-ill sick is not only impossible, but undesirable. Since health is culturally signaled by freedom from acute physiological pathologies and cure by medical-model intervention, those who are chronically ill and not physiologically responsive to such "appropriate" intervention are blamed as perfection-averse individuals to resist death. Their minds are numbed by the anesthesia of psychochemical intervention while their bodies are culturally tested, refusing the idea of prolonged death.

Thus, nursing homes are cultural products. They are part of the machinery of living and dying in industrialized societies. Best likely, nursing homes are commonly viewed as edifices to humanitarian ideals. Nonetheless, the endless workings of sociological, cultural, and medical forces exert pressures on human groups to deal with illness and death in culturally relevant and behaviorally expected ways.

The future is likely to see a proliferation of nursing homes as we know them today. Given this projection, research efforts may tend to directed at maximum stimulation and enhancement of minimally evolved beneficial behaviors and roles within a nursing home community. The cost-benefit ratio of the enhancement of pre-existing behavioral systems is seen as potentially attractive to proprietary nursing home owners for the improvement of the quality of institutional life.

APPENDIX 1
SELECTED HOSPITAL ADMISSIONS 1977

	Delaware	United States
Resident Patients	13,580	1,150,608
Discharge Rate	17,008	1,171,008
Number of beds per 1000 population aged 15 and over	45-1	48-3
Surgeon's Rate	47-2	48-2
Delays in the Process	-507	427

Source: Delaware Health Systems Agency, page 16

APPENDIX 1
 PRIOR CASES FROM TOTAL DISEASE SYSTEM
 (From physician listings in patients' charts)

	Number of Times Entered in Patient Charts
1. Advanced age	1
2. Agenesis	1
3. Angina	1
4. Anal. Fissure	1
5. Anemia	1
6. Anurysm	1
7. Angina Pectoris	2
8. Arteria Spasmodica Pectoris	1
9. Aphasia	2
10. Arteriosclerosis	2
11. Arteriosclerosis Cereb. System	1
12. Arthralgia	3
13. Arthritis	21
14. Arteriovascular Cerebral Insufficiency AOS	14
15. Arteriovascular Cerebral Insufficiency AOS	24
16. Arteriovascular Cardio-Vascular Disease AOS	24
17. Arteriovascular Systemative Disease AOS	20
18. Arthra	2
19. Arrial Prolapsion	1
20. Back Pain	1

FIGURE 1. TOTAL DISEASE BURDEN, 1990

		Number of Times Reported in Patient Charts
01	Bedfast/Chairfast	3
02	Blepharitis	3
03	Blood Sugar Monitor	1
04	Brain Stimulation	1
05	Cancer	4
06	Cardiac Arrhythmia	4
07	Cardiomyopathy	1
08	Cataracts	2
09	Cerebral Ischemia & Transient CI	3
10	Cerebral palsy	1
11	Cholecystectomy	1
12	Cholelithiasis	4
13	Chronic Acute Syndrome	4
14	Chronic Obstructive Pulmonary Disease COPD	3
15	Cerebral Insufficiency (CI)	3
16	Cerebral Insufficiency (CI)	14
17	Club Foot	1
18	Crinia	3
19	Cystitis	1
20	Digestive System Pathology (DIP)	4
21	Cervical Disorder	1
22	Cerebral Artery Disease (CAD)	1
23	Cerebral Artery Disease (CAD)	7

F O H. TOTAL MORGAN MORTAL, 1900

	<u>Number of Times Entered in Hospital Chart</u>
44. Cerebral Vascular Accident (CVA)	13
45. Optic	4
46. Degenerative Bone Disease	3
47. Degenerative Joint Disease (DJD)	1
48. Dementia	4
49. Deblility	7
50. Delirium	3
51. Dehydration	2
52. Depression	1
53. Dermatitis	1
54. Disturbed Nutrition	15
55. Diarrhea	2
56. Disorientation	1
57. Disturbances	20
58. Dysphagia	1
59. Dyspnea	3
60. Epilepsy, Focal, Fcl	1
61. Fractures	12
62. Gastric Neoplasia	1
63. Gastritis	3
64. Gastro-enteritis	1
65. Hallucinations	1
66. Spontaneous Cardio-Vascular Hemorrhage	21

P. 6.8 TOTAL CLINICAL SCORES, cont.

	Number of Signs Related to Perinatal Chorio.....
67. Hemiplegia	1
68. Hemiparesis	1
69. Hemia	1
70. Spastic paraparesis	12
71. Spastic paraplegia	3
72. Hypokinesia	3
73. Hypokinesidism	3
74. Dyskinesia	1
75. Indigestion	1
76. Laryngitis	1
77. Lumbago	1
78. Rheumatism	1
79. Stomatitis	3
80. Neurosis	1
81. Mental deterioration	1
82. Mental confusion	15
83. Mental deterioration	3
84. Mental retardation	3
85. Epileptic convulsions	3
86. Multiple sclerosis	3
87. Spontaneous abortion	3
88. Neurological deficits of structural hydrocephalus	1
89. Stenosis	1
90. Organic brain syndrome	4

 C H TOTAL DISEASE BURDEN 2002

		Number of Sites Entered in Patient Study
92	Osteoarthritis	22
93	Osteoporosis	1
94	Osteomyelitis	24
95	Osteomyelitis	1
96	Osteomyelitis	1
97	Osteomyelitis	4
98	Osteomyelitis	1
99	Osteomyelitis	1
100	Osteomyelitis	1
101	Osteomyelitis	1
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185	Osteomyelitis	1
186	Osteomyelitis	1
187	Osteomyelitis	1
188	Osteomyelitis	1
189	Osteomyelitis	1
190	Osteomyelitis	1
191	Osteomyelitis	1
192	Osteomyelitis	1
193	Osteomyelitis	1
194	Osteomyelitis	1
195	Osteomyelitis	1
196	Osteomyelitis	1
197	Osteomyelitis	1
198	Osteomyelitis	1
199	Osteomyelitis	1
200	Osteomyelitis	1

F C W TOTAL DISEASE ROSTER cont

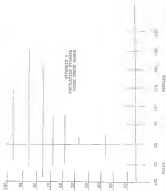
		Number of Times Entered in Patient Charts
115.	Shoulder Injury	1
116.	Stomatitis	1
117.	Speech difficulty	1
118.	Stokes Syndrome	2
119.	Strabism	2
120.	Synovitis	2
121.	Tachycardia	1
122.	Tooth abscess	1
123.	Thrombophlebitis	1
124.	Transient Ischemic Attack (TIA)	1
125.	Ulcus	1
126.	Urinary Tract Infection (UTI)	1
127.	Vulvitis	1

APPENDIX 1
 TCMAR CODED FORMS
 TEN MOST FREQUENT DISEASES

Disease	Number of cases	Percentage Rate
1. Arteriosclerosis	52	39.4%
2. Arteriosclerotic Cardiovascular Disease	29	26.8%
3. Arterio-sclerotic Coronary Insufficiency	28	32.3%
4. Hypertension	26	37.4%
5. Mental Confusion	24	33.3%
6. Hypertensive Cardiovascular Disease	23	34.3%
7. Coronary Insufficiency	18	18.1%
8. Arterio-sclerotic Coronary Insufficiency	14	17.0%
9. Cardiovascular Accident	17	18.0%
10. Fractures	15	15.0%

APPENDIX A
NATIONAL PHYSALOGY
FEDAL CODE PAGE

	23
Cardiovascular Disorders	2340
Neurologic Disorders	2342
Psychiatric Disorders	2343
Musculoskeletal and Connective Tissue Disorders	2440
Gastrointestinal Disorders	2442
Endocrine Disorders	2444
Immunologic	2444
Infectious and Parasitic Disorders	2448
Respiratory Disorders	2451
Ear, Nose and Throat Disorders	2452
Endocrine Disorders	2452
Ophthalmic Disorders	2452
Urologic and Gynecologic Disorders	2452
Genitourinary and Obstetric and Neonatal Disorders	2452
Infectious and Parasitic Disorders	2454
Neurologic Disorders	2454
Neurologic Disorders	2454
Cancer Disorders	2454



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